

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
02102		CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR		
MARY		F.		ALTEVOGT	FEBRUARY 9, 1968		1:40		AM
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
FEMALE	WHITE		AUGUST 5, 1893		74 YRS.		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		U.S.A.				BALTIMORE Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
TOWSON		ST. JOSEPH HOSPITAL		HOMEMAKER					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND				BALTIMORE				3501 PARKSIDE DRIVE #21214	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
Joseph				Murphy	Mary				Kelly
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
no		216-09-9405		Wm. J. Altevogt		2313 Ravenview Rd. 21093			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain lesion - possible tumor</u> 2381 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>207X</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Septicemia / Arteriosclerotic Heart Disease/ Diabetes Mellitus</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>JANUARY 24, 1968</u> , to <u>FEBRUARY 9 1968</u> , that (I) (we) last saw the deceased alive on <u>FEBRUARY 9 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>A. S. Sayoc M.D.</u>						22c. DATE SIGNED		FEBRUARY 9, 1968	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
DR. ALEXIS SAYOC, M.D.				7620 YORK ROAD TOWSON, MD. #21204					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
burial		2/12/68		Moreland Memorial		Balto.		Md.	
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE	
Mitchell-Wiedefeld Home				6500 York Rd. Balto., Md. 21212		FEB 13 1968		<u>[Signature]</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) FLORENCE CATHERINE ARNOLD			First Middle Last			2a. DATE OF DEATH Month 2 Day 4 Year 1968			2b. HOUR 12 30 PM			
3. SEX F.		4. RACE W.		5. DATE OF BIRTH 10-13-1903			6. AGE (In years last birthday) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County Md.						
10. CITY OR TOWN OF DEATH Mt. Wilson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Wilson State Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY CARROLL			13c. CITY OR TOWN WESTMINSTER		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER RT. 4		
14. FATHER'S NAME First Middle Last BENJAMIN FLOHR			15. MOTHER'S MAIDEN NAME First Middle Last CARRIE FOWBLE									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 220-16-1580			17. INFORMANT Address Records, Mt. Wilson State Hospital						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1621 IMMEDIATE CAUSE (a) CARCINOMA OF THE LUNG DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MONTHS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1638												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from OCTOBER 31, 1968 , to FEB. 4, 1968 , that (I) (we) last saw the deceased alive on FEB. 4, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE W. Newcomer						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED FEB. 4-1968				
22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.						22e. ADDRESS Mount Wilson, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 2/7/68		23c. NAME OF CEMETERY OR CREMATORY DEER PARK METH. CEMETERY		23d. LOCATION (City or Town) (County) (State) SMALLWOOD, CARROLL Co. MD						
24. FUNERAL DIRECTOR J. S. Myers, Jr. Westminster, Md.						25a. REC'D BY REGISTRAR DATE FEB 7 1968		25b. REGISTRAR'S SIGNATURE John J. Jones				

0130

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		
Robert			P		Ash		2		Month 2 Day 68 Year 11:13aM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Male		Cau		February 3, 1921			46 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Penna.			USA				Baltimore Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore Towson			Greater Balto. Medical Center			Sales man / 1 yr.			Medical Co.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Baltimore		Lutherville		YES		115 Ardoon Road		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
John Ash			Jenny?								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address						
No			None		186-09-7843 Family records						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral hemorrhage</u>											
4120 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) <u>Hypertensive cardiovascular disease</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
4438											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 2/1, 1968, to 2/2, 1968, that (I) (we) last saw the deceased alive on 2/2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John E. Adams, M.D. DEGREE						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 2/2/68		
22d. PHYSICIAN'S NAME (Type) John E. Adams, M.D.						22e. ADDRESS 6701 N. Charles Street					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Removal/ Burial			Feb. 6, 1968		Whitemarsh Memorial Park			Prospectville, Phila., Pa.			
24. FUNERAL DIRECTOR ADDRESS John Burns' Sons, Towson, Maryland						25a. REC'D BY REGISTRAR DATE FEB 6 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		

52036

65164

John E. Adams

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div>02105</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>02093</div>											
1. DECEASED NAME (Type or Print) HARRY R. ASHE						2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> 7 th 1968			2b. HOUR 7:30 P.M.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH Nov. 22, 1894		6. AGE (In years (at birthday)) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Feb. Day 7 Year 1968	
7a. BIRTHPLACE (State or foreign country) Balto. Co.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto. Co.			
10. CITY OR TOWN OF DEATH Upperco				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Gorsuch Mill Rd.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Machinist		12b. KIND OF BUSINESS OR INDUSTRY Black & Decker	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Balto.		13c. CITY OR TOWN Upperco		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER East View Dr.	
14. FATHER'S NAME First Isaac M. Middle Ashe						15. MOTHER'S MAIDEN NAME First Emma Middle J. Last Cox					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16b. SOCIAL SECURITY NO. 216-28-8171		17. INFORMANT ADDRESS Vernon Ashe Glenarm, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shotgun Wound 7 head DUE TO, OR AS A CONSEQUENCE OF 955X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Instant	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 976X											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year 7:22 P.M. 2/7 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Farm		21f. LOCATION Street or R.F.D. No. City or Town County State Upperco Balto. Co. Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE A. M. France						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) A. M. FRANCE						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> : 22b. DATE SIGNED 2/7/68					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						ADDRESS (Street, city, town, or county) PARKVIEW Hl					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE Feb. 9, 1968		23c. NAME OF CEMETERY OR CREMATORY Salem Cemetery		23d. LOCATION (City or Town) (County) (State) Hampstead Balto. Co. Md.			
24. FUNERAL DIRECTOR Tipton - Eline Funeral Home Hampstead, Md.						25a. REC'D BY REGISTRAR DATE FEB 14 1968		25b. REGISTRAR'S SIGNATURE			

52880

50130

STANDARD INTERNATIONAL

DATE
TIME

[Faint, illegible text and markings covering the main body of the page, possibly bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)		First CHARLES		Middle		Last ATKALN		2a. DATE OF DEATH February Month 24 , Day 1968 Year		2b. HOUR M
3 SEX Male		4. RACE White		5. DATE OF BIRTH 11-28-1893		6. AGE (In years last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Lavia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore		Md.		
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Shangri La Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5434 Addington Road 21229		
14. FATHER'S NAME First Middle Last Unknown				15. MOTHER'S MAIDEN NAME First Middle Last Unknown				Address 21229		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 212-10-2528		17. INFORMANT Mrs. Hilda H. Atkain, 5434 Addington Rd.		Address 21229				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.N.A. RT. 4369 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Arterio sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Age APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 246 82										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 3318										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 1/23 , 19 68 , to 2/24 , 19 68 , that (I) (we) lost saw the deceased alive on 1/23 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Cliff Ratliff, Jr.		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2/26/68				
22d. PHYSICIAN'S NAME (Type) Dr. Cliff Ratliff, Jr.		22e. ADDRESS 4605 Edmondson Avenue, Balto., Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE 2-27-1968		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland				
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		ADDRESS		25a. REC'D BY REGISTRAR DATE FEB 29 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				

MEDICAL CERTIFICATION

09180

4230

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001-282 9-25 6-77 30 11-3 21-12-28

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1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

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$\frac{1}{x^2} = x^{-2}$, $\frac{d}{dx} x^{-2} = -2x^{-3} = -\frac{2}{x^3}$

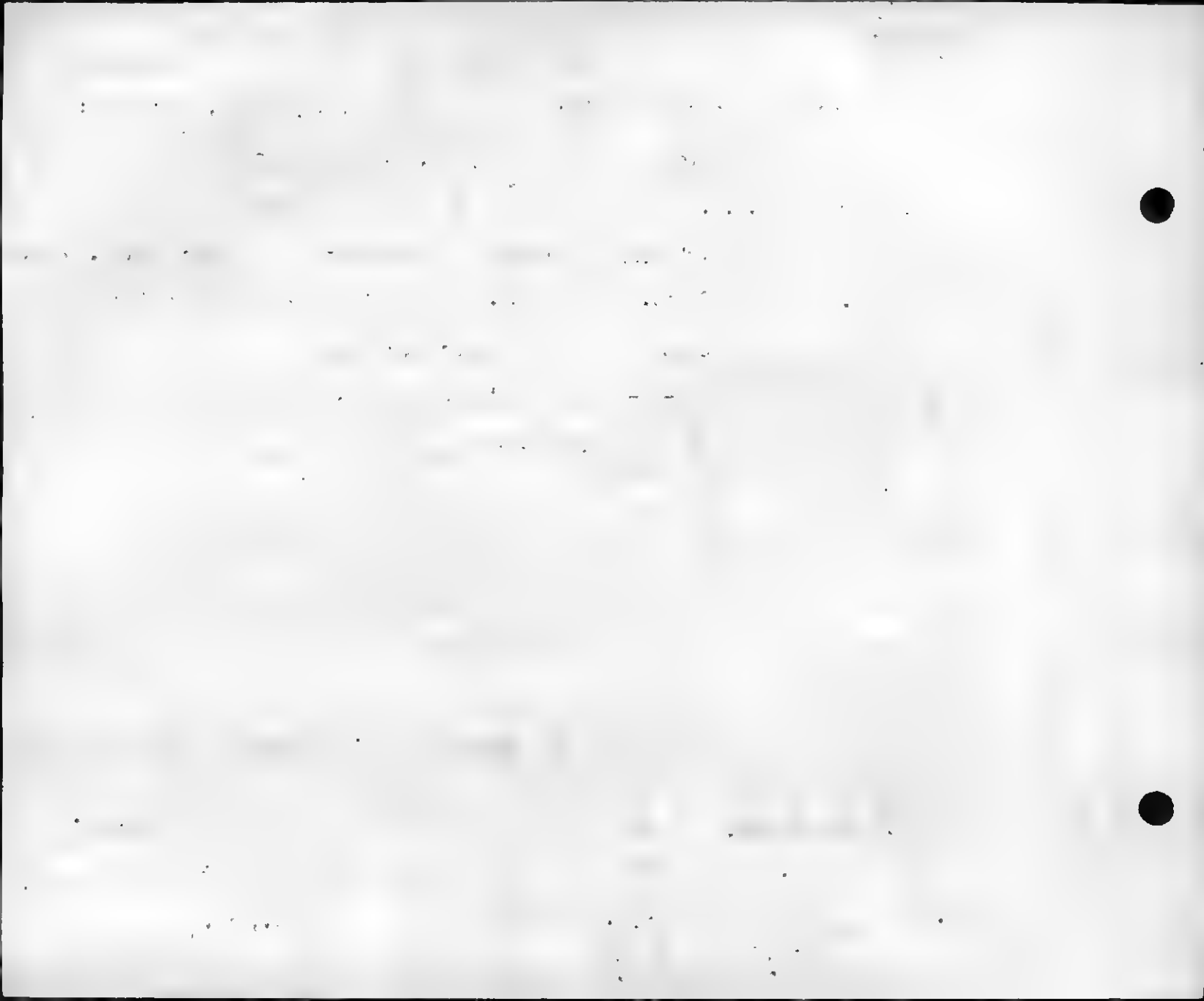
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2002, 2003, 2004, 2005, 2006, 2007, 2008

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) First Middle Last Charles Joseph Baier						2a DATE OF DEATH Month Day Year February 29, 1968			2b HOUR 8:15 p.m.		
3 SEX male		4 RACE white		5. DATE OF BIRTH May 10, 1900			6 AGE (In years last birthday) 67 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (State or foreign country) Baltimore		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md.					
10 CITY OR TOWN OF DEATH Baltimore			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5104 McFaul Road #6			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Salesman			12b KIND OF BUSINESS OR INDUSTRY Ltd. Balto. Laundry		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Balto.		13c CITY OR TOWN Balto.		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13a. STREET AND NUMBER 5104 McFaul Road #6			
14 FATHER'S NAME First Middle Last Peter Baier				15. MOTHER'S MAIDEN NAME First Middle Last Laura Walstrom							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) no				16b. SOCIAL SECURITY NO. 213-05-4778		17. INFORMANT Address Catherine Baier, wife, above					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerosis, generalized 1409 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21a. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC.		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a I certify that (I) (this hospital) attended the deceased from Jan , 19 68 , to Feb , 19 68 , that (I) (we) last saw the deceased alive on Feb 29 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dr. Robert Lyden						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 3/2/68			
22d PHYSICIAN'S NAME (Type) Dr. Robert Lyden		22e. ADDRESS 6402 Golden Ring Road									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 3/4/68		23c NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery				23d LOCATION (City or Town) (County) (State) Balto., Md.			
24 FUNERAL DIRECTOR Schimunek Funeral Home 3331 Brehms Lane #13		ADDRESS		25a. REC'D BY REGISTRAR DAK 5 1968		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]					



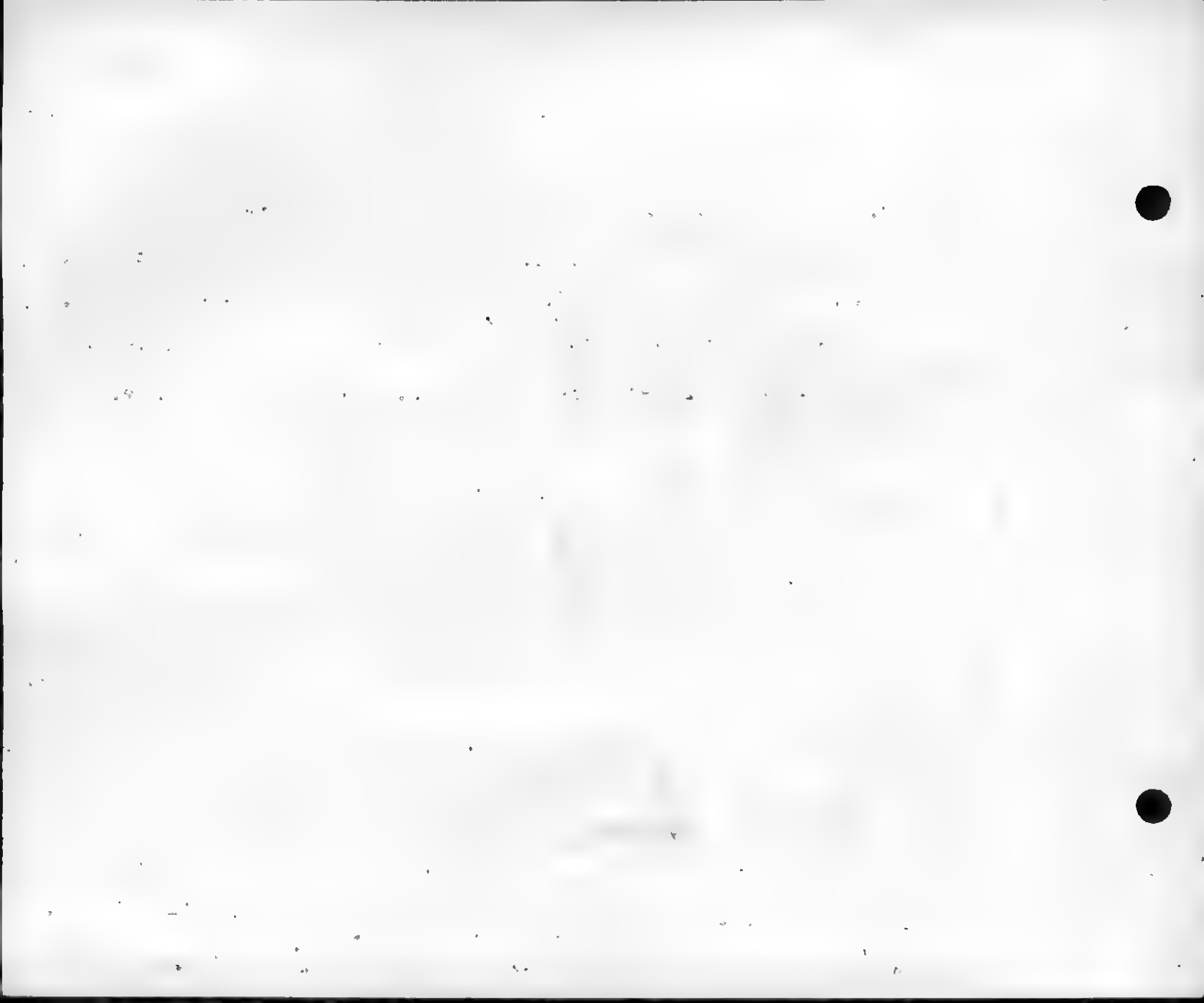
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VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH			2b. HOUR				
MARIE (MARY)		B.	BAUERNSCHMIDT		2	Month	3	Day	68	Year	8:50a	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Female		Caucasian				62 YRS.		MONTHS		DAYS		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Balto., Md.		U.S.A.				Baltimore		Md.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY						
Towson		Greater Balto. Med. Center		House Work		At Home.						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY, I.M. TS?		13e. STREET AND NUMBER				
Md.		✓		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3325 Hudson St. #21224.				
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last			
Martin		Bauernschmidt		Anna		Strugala						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address						
8		214-03-2369		Martin J. Bauernschmidt		Same.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <u>Septicemia</u>												
DUE TO, OR AS A CONSEQUENCE OF												
(b) <u>Acute bacterial endocarditis</u>												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
<u>Diabetes mellitus</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION		Street or R.F.D. No		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>1/24, 1968</u> , to <u>2/3, 1968</u> , that (I) (we) last saw the deceased alive on <u>2/3, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>John E. Adams</u> DEGREE										22c. DATE SIGNED <u>2/3/68</u>		
22d. PHYSICIAN'S NAME (Type) <u>John E. Adams, M. D.</u>										22e. ADDRESS <u>Greater Baltimore Medical Center</u>		
23a. BURIAL, CREMATION, REMOVAL <u>Burial</u>		23b. DATE <u>2-7-68.</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cemetery</u>		23d. LOCATION (City or Town) <u>7401 German Hill Rd</u>		(County) <u>Ba.</u>		(State) <u>Md.</u>		
24. FUNERAL DIRECTOR <u>Charles J. Jailer</u>		ADDRESS <u>901 S. Conkling St. Balto., 21224, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 6 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>						



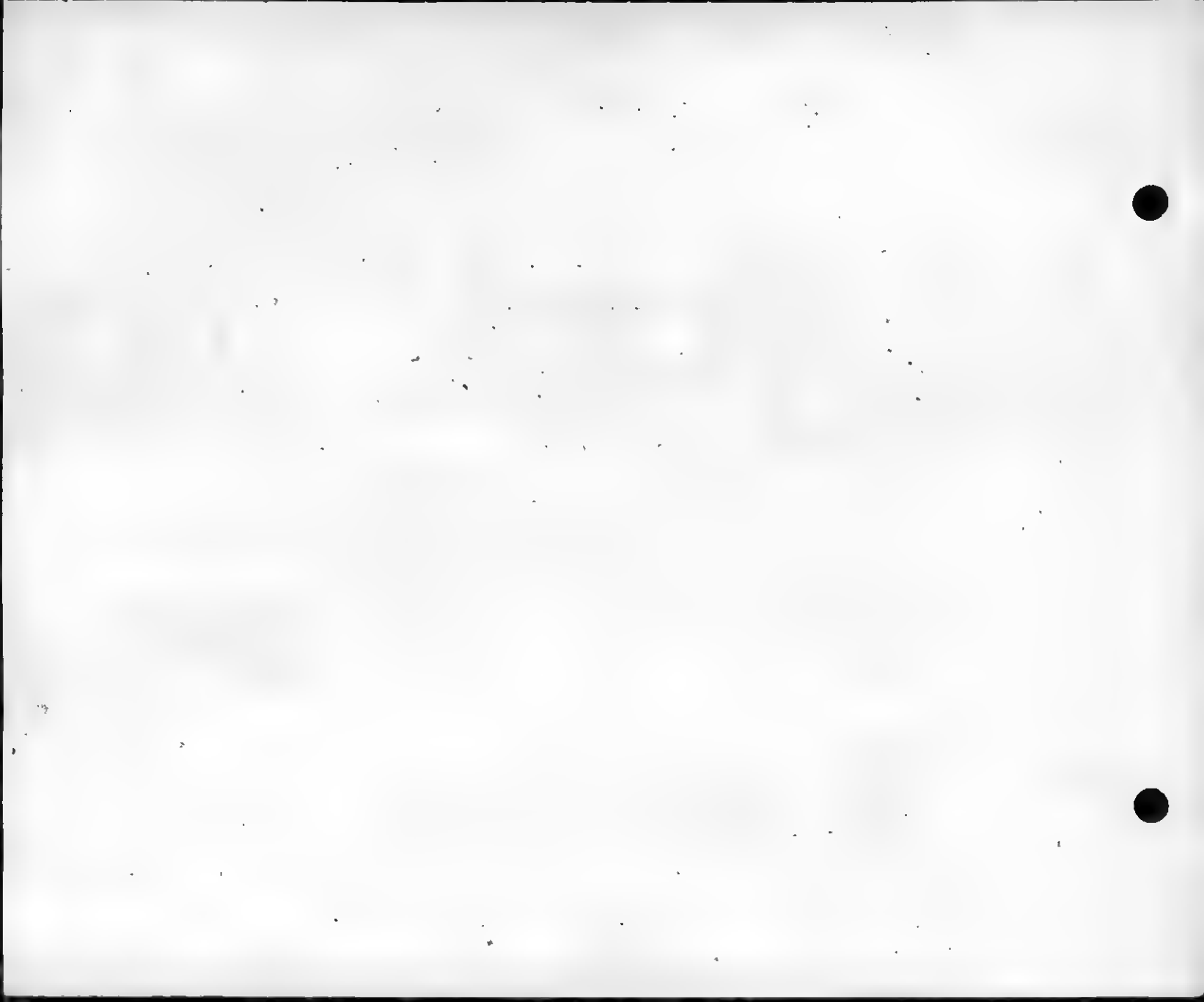
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MD
22101
MAYARD STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

0268K

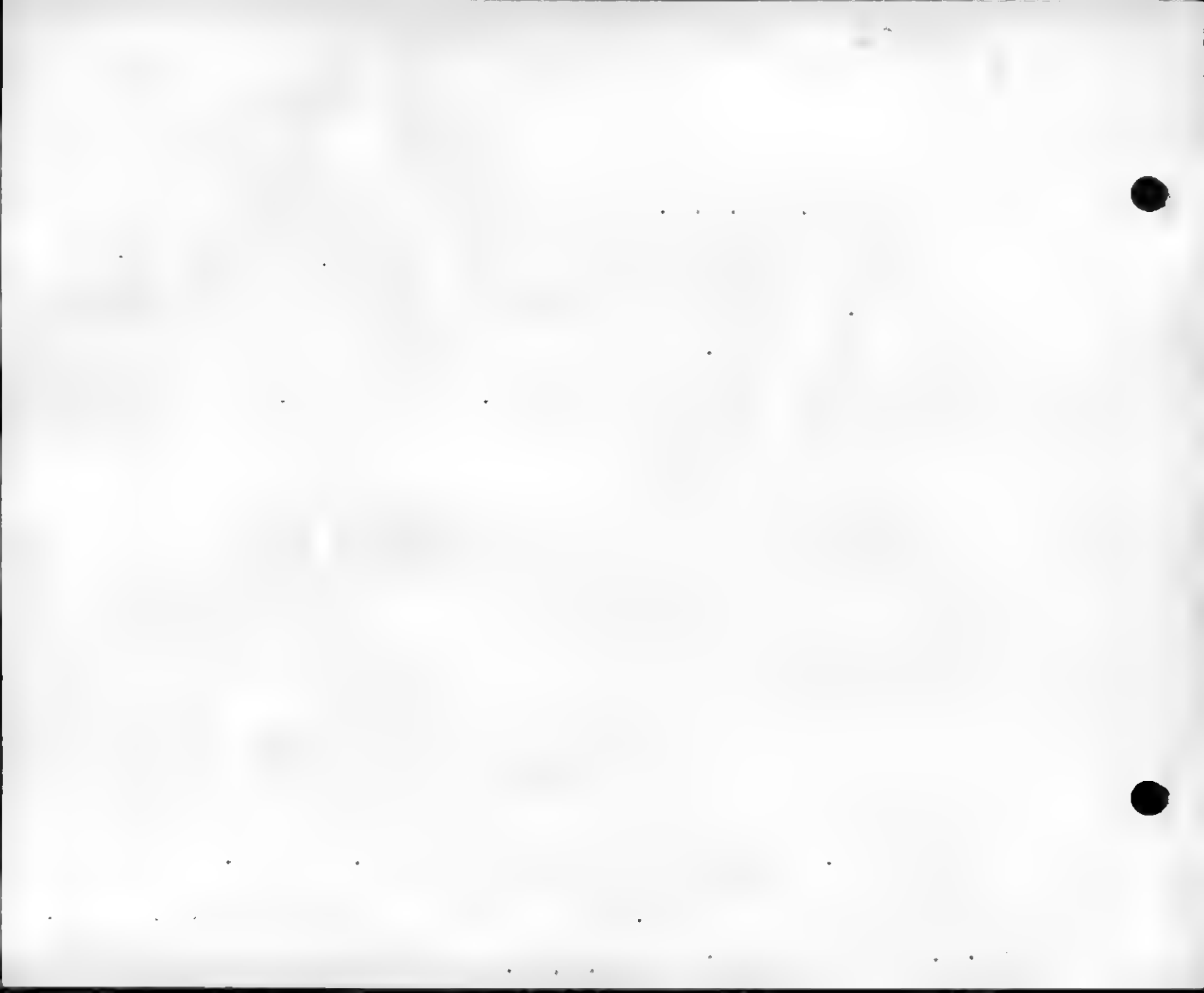
1 DECEASED NAME (Type or print) First Middle Last EMILY ELIZABETH BAUGHER		2a. DATE OF DEATH Month Day Year 2 23 68		2b. HOUR 4:55a M
3 SEX Female	4. RACE Caucasian	5. DATE OF BIRTH June 5, 1902		6 AGE (in years last birthday) 65 YRS.
7a BIRTHPLACE (State or foreign country) Daniel Md		7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 COUNTY OF DEATH Baltimore Md				
10 CITY OR TOWN OF DEATH Towson	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med. Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md	13b. COUNTY Howard	13c. CITY OR TOWN Elkridge	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Box 241 Rt 4
14 FATHER'S NAME First Middle Last Joseph Stevens		15 MOTHER'S MAIDEN NAME First Middle Last Nettie Castle		
16a. WAS DECEASED EVER IN THE ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17 INFORMANT Mrs. Lillian McQuinn, Elkridge City Md
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> 154, DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of rectum</u> DUE TO, OR AS A CONSEQUENCE OF (c)				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from <u>1/30, 1968</u> , to <u>2/23, 1968</u> , that (I) (we) last saw the deceased alive on <u>2/23, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE John E. Adams		22c. DATE SIGNED 2/23/68		
22d. PHYSICIAN'S NAME (Type) John E. Adams, M. D.		22e. ADDRESS Greater Baltimore Medical Center		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-26-68	23c. NAME OF CEMETERY OR CREMATORY Marianville Mem	23d. LOCATION (City or Town) Lanney Md	(County) (State)
24 FUNERAL DIRECTOR S. E. McQuinn		25a. REC'D BY REGISTRAR DATE FEB 29 1968		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]



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<div>02110</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>02034</div>																
1. DECEASED-NAME (Type or print)			First John			Middle Baylor			Last Baylor			2a. DATE OF DEATH Month February Day 23 Year 1968			2b. HOUR 12:20 ^P M	
3. SEX M			4. RACE W			5. DATE OF BIRTH 11/5/1889			6. AGE (In years last birthday) 78 YRS.			IF UNDER 1 YEAR MONTHS 78 DAYS 78		IF UNDER 24 HRS. HOURS 78 MIN 78		
7a. BIRTHPLACE (State or foreign country) Richmond, Va.			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore					Md		
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 329 Southwind Road			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Lawyer			12b. KIND OF BUSINESS OR INDUSTRY Law							
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.			13b. COUNTY Baltimore			13c. CITY OR TOWN Towson			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 329 Southwind Road				
4. FATHER'S NAME First James Middle B. Last Baylor			15. MOTHER'S M.A.DEN NAME First Ellen Middle Carter Last Bruce													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes (If yes give war or dates of service) WWI			16b. SOCIAL SECURITY NO. 220-44-0430T			17. INFORMANT Mrs. Sophie Fisher Baylor			Address (Same)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of pancreas DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2 1/2 years DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 years				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) None																
19a. DATE OF OPERATION Nov. 6, 67			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of pancreas			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC.			21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that (I) (this hospital) attended the deceased from Dec. 13 , 19 65 , to Feb. 23 , 19 68 , that (I) (we) last saw the deceased alive on Feb. 22 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE John Tilden Howard, M.D.			DEGREE M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/>			STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED Feb. 24, 1968	
22d. PHYSICIAN'S NAME (Type) Dr. John Tilden Howard			22e. ADDRESS 12 E. Eager St.													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 2/26/68			23c. NAME OF CEMETERY OR CREMATORY St. Thomas'			23d. LOCATION (City or Town) (County) (State) Garrison Forest, Md.							
24. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md.			25a. REC'D BY REGISTRAR FFB 26 1968			25b. REGISTRAR'S SIGNATURE Charles Judge										



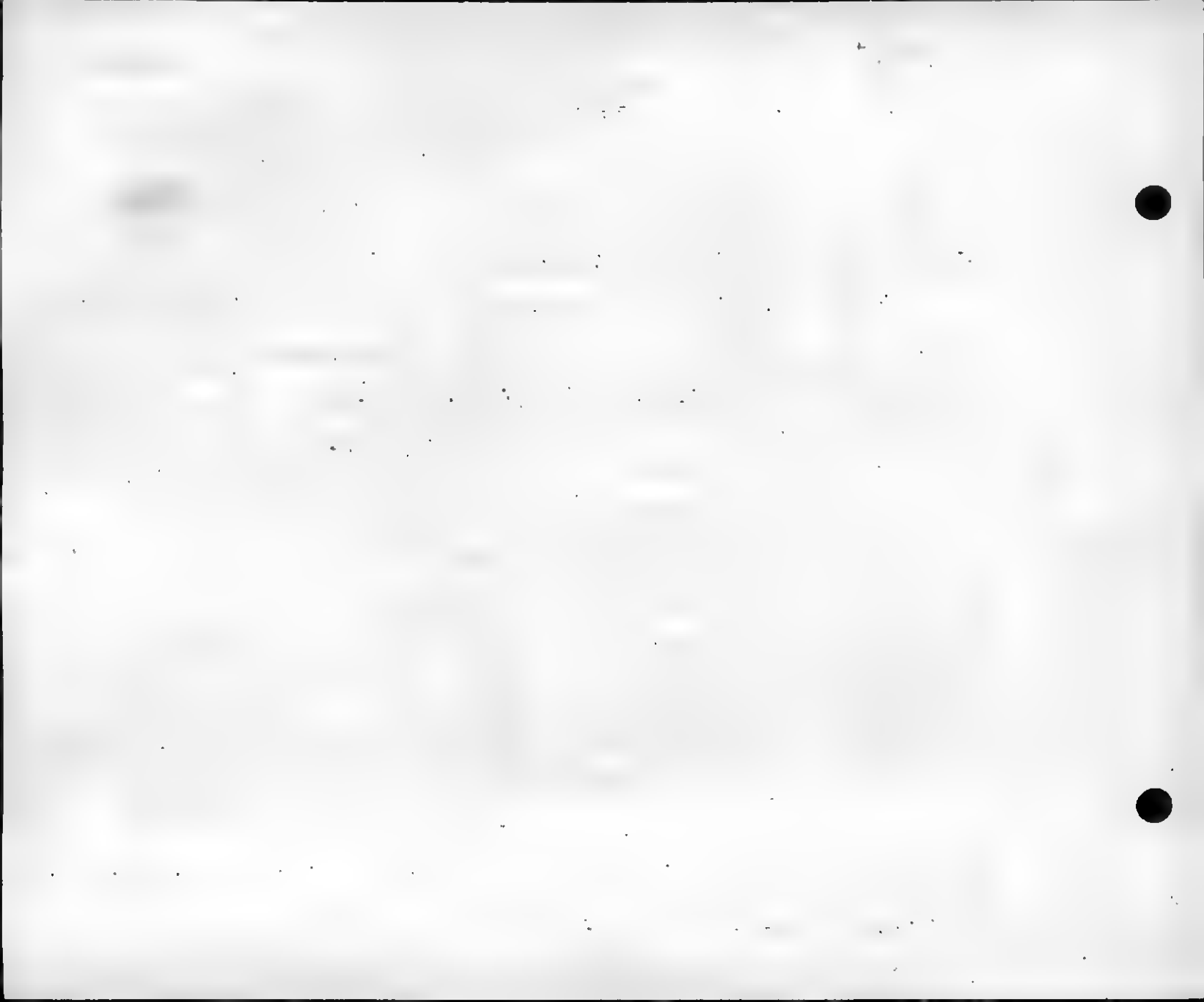
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last WILLIAM C. BEAL SR.			2a DATE OF DEATH 2 Month 23 Day 68 Year		2b. HOUR M
3. SEX 7	4. RACE W	5. DATE OF BIRTH 11/28/24		6. AGE (In years last birthday) 43 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS M.N.
7a. BIRTHPLACE (State or foreign country) PA	7b. CITIZEN OF WHAT COUNTRY? U.S.	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE Md.		
10. CITY OR TOWN OF DEATH CATONSVILLE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 720 DORCHESTER RD		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) STEAM FITTER	12b. KIND OF BUSINESS OR INDUSTRY MAINT.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY BALTO.	13c. CITY OR TOWN CATONSVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 720 DORCHESTER RD.
14 FATHER'S NAME First Middle Last ROLLO C BEAL			15. MOTHER'S MAIDEN NAME First Middle Last NORA SMERMAN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO 175204943	17. INFORMANT ARLENE BEAL Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 191X Cardiac failure DUE TO, OR AS A CONSEQUENCE OF (b) Malignant Brain Tumor DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24h 3 months					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 191X					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 12/12, 1967, to 2/23, 1968, that (I) (we) last saw the deceased alive on 2/23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Cliff Ratliff, Jr., M.D.				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 2/24/68
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 4605 Edmondson Avenue, Balto., Md., 21229			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 2/26/68	23c. NAME OF CEMETERY OR CREMATORY LAKE VIEW	23d. LOCATION (City or Town) (County) (State) SPRINGVILLE Md.		
24. FUNERAL DIRECTOR E.S. MACNAB		ADDRESS 301 FREDERICK RD 21228		25a. REC'D BY REGISTRAR DATE FEB 26 1968	25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

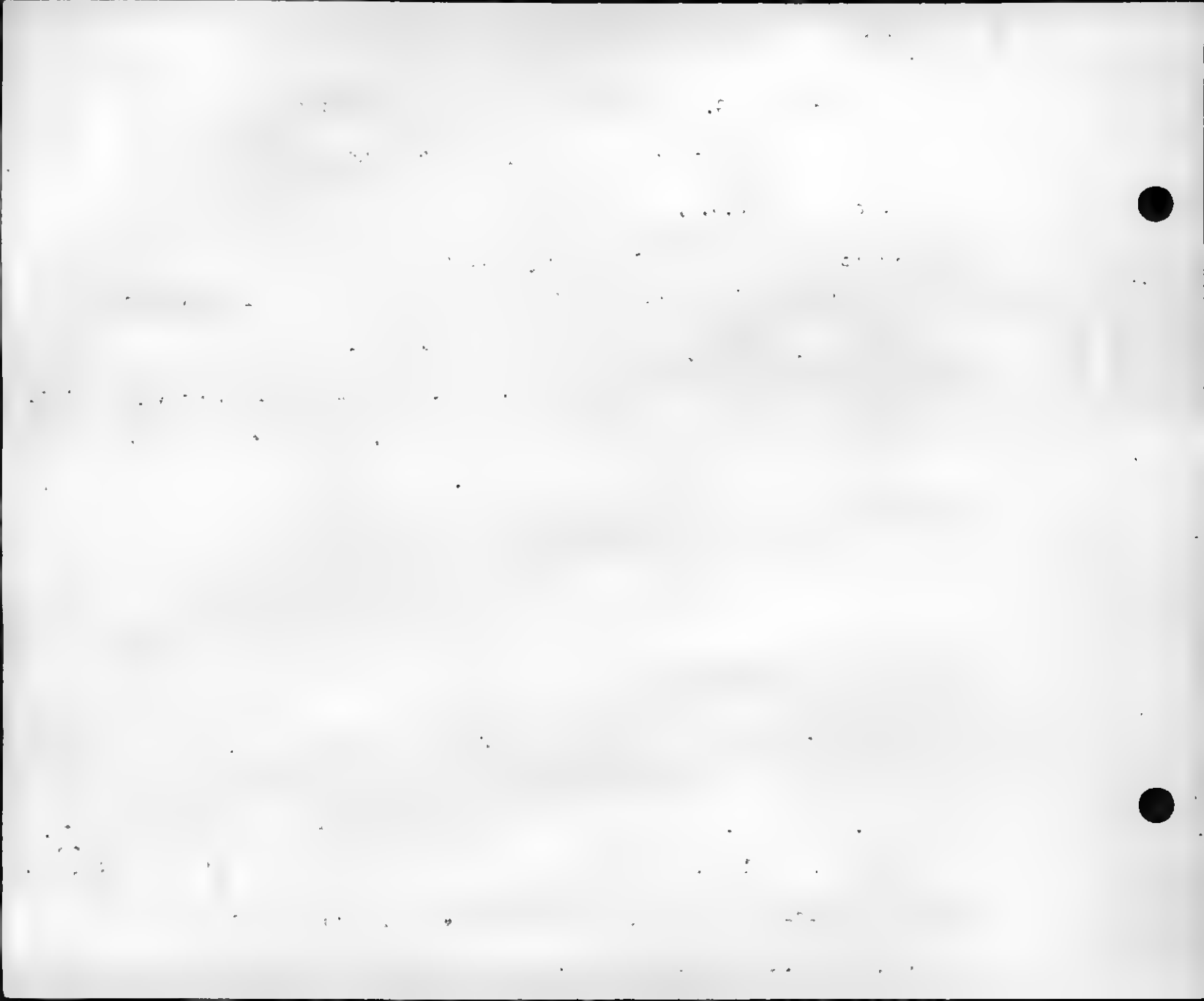
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



2112
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02101

1 DECEASED NAME (Type or print) ADDIE G. BEALL			First Middle Last			2a. DATE OF DEATH February 29, 1968			2b. HOUR 6:45 PM		
3 SEX Female			4 RACE White			5 DATE OF BIRTH August 30, 1885			6 AGE (n years lost birthday) 82 YRS		
7a BIRTHPLACE (State or foreign country) Virginia			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md.		
10 CITY OR TOWN OF DEATH Catonsville			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bloomsbury Retreat			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Baltimore			13c CITY OR TOWN Towson			13d INSIDE CITY I.M.T.S? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME First Middle Last John J. George			15 MOTHER'S MAIDEN NAME First Middle Last Elizabeth Raines			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b SOCIAL SECURITY NO 231-12-3951		
17 INFORMANT Mr. Gordon Bonner, 544 Park Avenue			Address 21204			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ruptured ABD. ANEURYSM, AORTA 441.2- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ATHEROSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH OCT-1967 15 YRS.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC)			21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 5/17 , 19 66 , to 2/29 , 19 68 , that (I) (we) last saw the deceased alive on 2/17 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE Paul R. Ziegler			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c DATE SIGNED 2/29/68			22d. PHYSICIAN'S NAME (Type) Dr. Paul R. Ziegler		
22e ADDRESS 200 Chestnut Hill Drive, City, Md.			23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b DATE 3-2-1968			23c NAME OF CEMETERY OR CREMATORY Harmony Village Cemetery		
23d LOCATION (City or Town) (County) (State) Harmony Village, Virginia			24 FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave.			ADDRESS 21229			25a. REC'D BY REGISTRAR DATE MAR 4 1968		
25b REGISTRAR'S SIGNATURE Charles Judge											

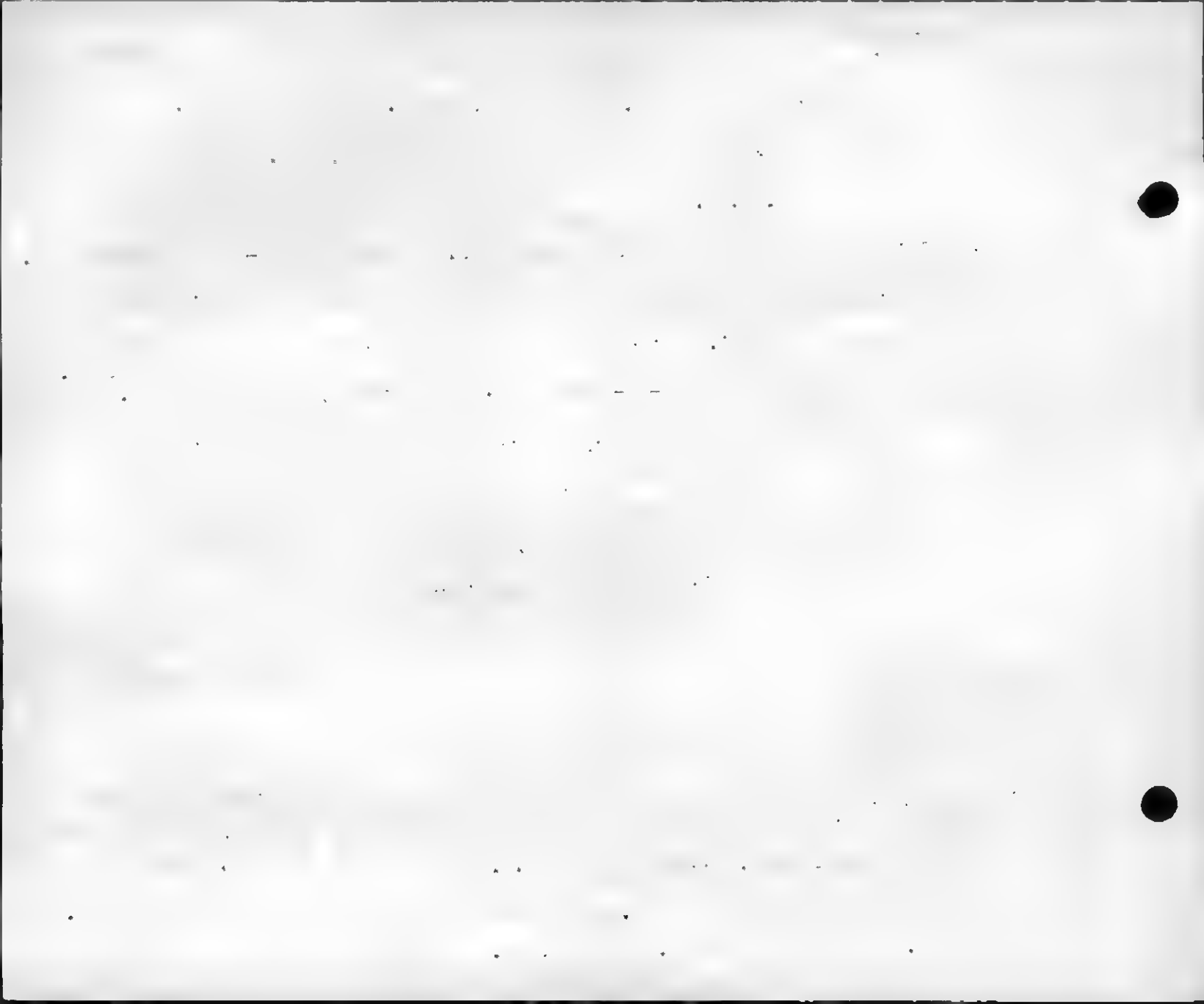


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form (P) Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		2b. HOUR
Edward		H.				Becker Sr.		Month Day Year Feb. 23 1968		M
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year Feb. 23 1968	
Male	White	12/12/07		60					2d. HOUR	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md		
Maryland		U. S. A.				Baltimore				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Dundalk		215 Parkwood Rd.				Truck Driver- A A A		Trucking Co.		
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Maryland		Baltimore		Dundalk				215 Parkwood Road		
14 FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last
Henry		E.				Becker		Virginia		Mehring
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO (No number or dates of service)		17. INFORMANT (Wife)		ADDRESS		Dundalk, Md.		
Yes		WWII		217-26-9995		Mrs. Edith Becker, 215 Parkwood Rd.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u>										
DUE TO, OR AS A CONSEQUENCE OF <u>ACVD</u>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b)										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
<u>Diabetes mellitus</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/>		21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
CAUSE OF DEATH		19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		Theodore C. Patterson				M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> 105 Main Street		
								22b. DATE SIGNED		
								2/23/68		
EXAMINER'S NAME (Type)		Theodore C. Patterson				M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Dundalk		
								ADDRESS (Street, city, town, or county) Md. 21222		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		2/26/68		Mt. Carmel Cemetery		Baltimore, Md.				
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REG. STRAR		
John J. Duda, 7922 Wise Ave.						Dundalk, Md.		25b. REG. STRAR'S SIGNATURE		
								FEB 27 1968		

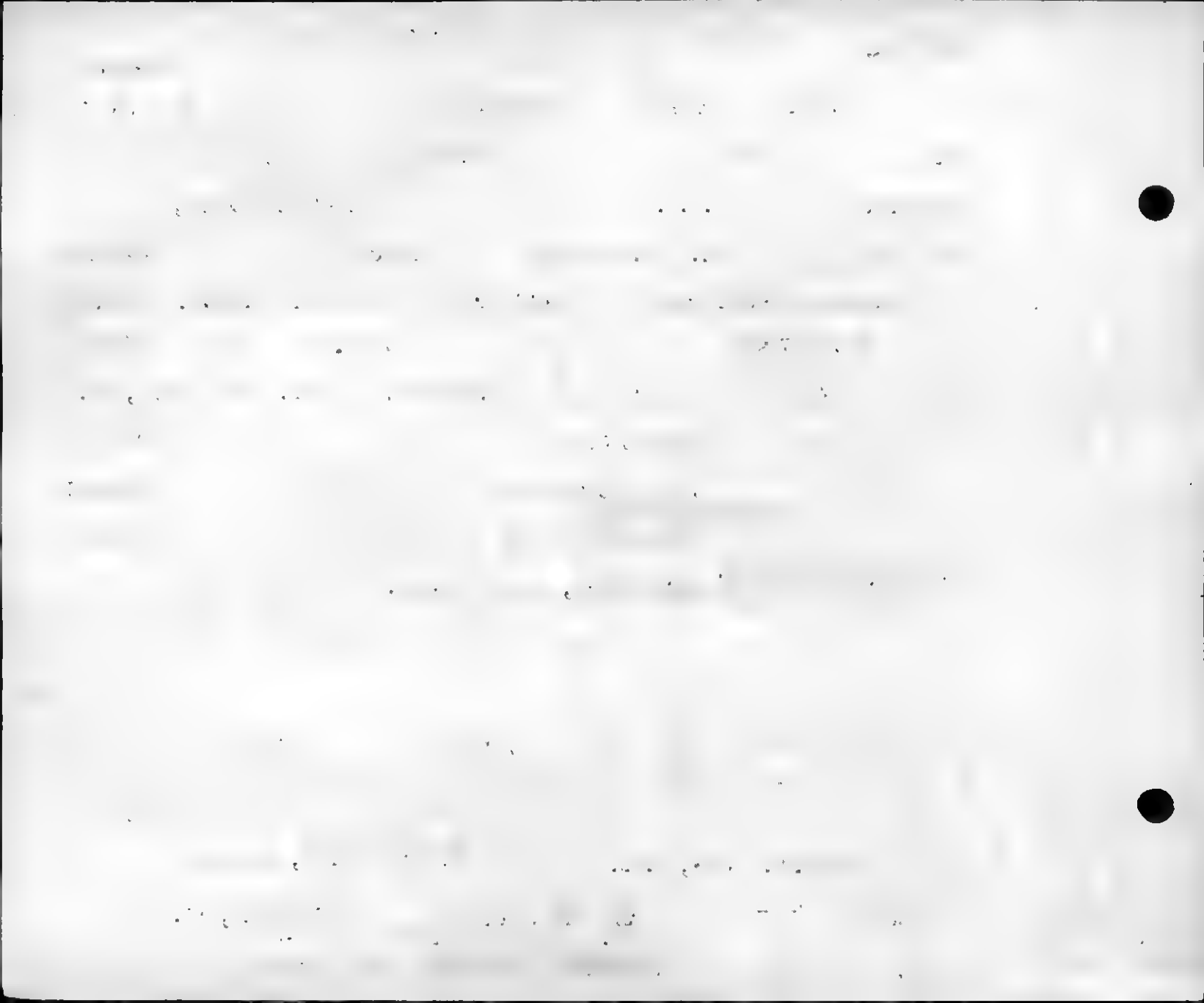


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VR 157 (1)
304 REV. 1-58

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First WILBERT			Middle WESLEY			Last BEEMAN			2a. DATE OF DEATH Month 2 Day 29 Year 68			2b. HOUR 11:45AM		
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 2/20/24/			6. AGE (In years last birthday) 44 YRS			IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS HOURS MIN.					
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE COUNTY,			Md.					
10. CITY OR TOWN OF DEATH FORT HOWARD			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) D VET. ADM. HOSPITAL			12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) LABORER			12b. KIND OF BUSINESS OR INDUSTRY RAILROAD								
13a. USUA. RES DENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND			13b. CITY WASHINGTON			13c. CITY OR TOWN HAGERSTOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER ROUTE 1, BLACK ROCK ROAD					
14. FATHER'S NAME First ELIJAH Middle BEEMAN Last			15. MOTHER'S MAIDEN NAME First CLARA Middle BELL Last CLISE														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) YES WW II			16b. SOCIAL SECURITY NO 218 12 58 57			17. INFORMANT CLIN. RECORDS, VA HOSP. FORT HOWARD, MD.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC COMA DUE TO, OR AS A CONSEQUENCE OF (b) CIRRHOSIS OF LIVER (c) BRONCHOPNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last PULMONARY CONGESTION. BILATERAL AMPUTATION ABOVE KNEES, DUE TO TRAUMA.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS UNKNOWN RECENT					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR AM Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that I (this hospital) attended the deceased from 2/20/68 , 19 68 , to 2/29/68 , 19 68 , that I (we) lost saw the deceased alive on 2/29/68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>Peter V. Juvan</i>												22c. DATE SIGNED 2/29/68					
22d. PHYSICIAN'S NAME (Type) PETER V. JUVAN, M. D.						22e. ADDRESS VAH FORT HOWARD, MARYLAND											
23a. BURIAL, CREMATION, REBURY (Type) BURIAL			23b. DATE 3-4-68			23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY			23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, MD.								
24. FUNERAL DIRECTOR MINNICK FUNERAL HOME HAGERSTOWN, MARYLAND						25a. REC'D BY REGISTRAR MAR 4 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>									



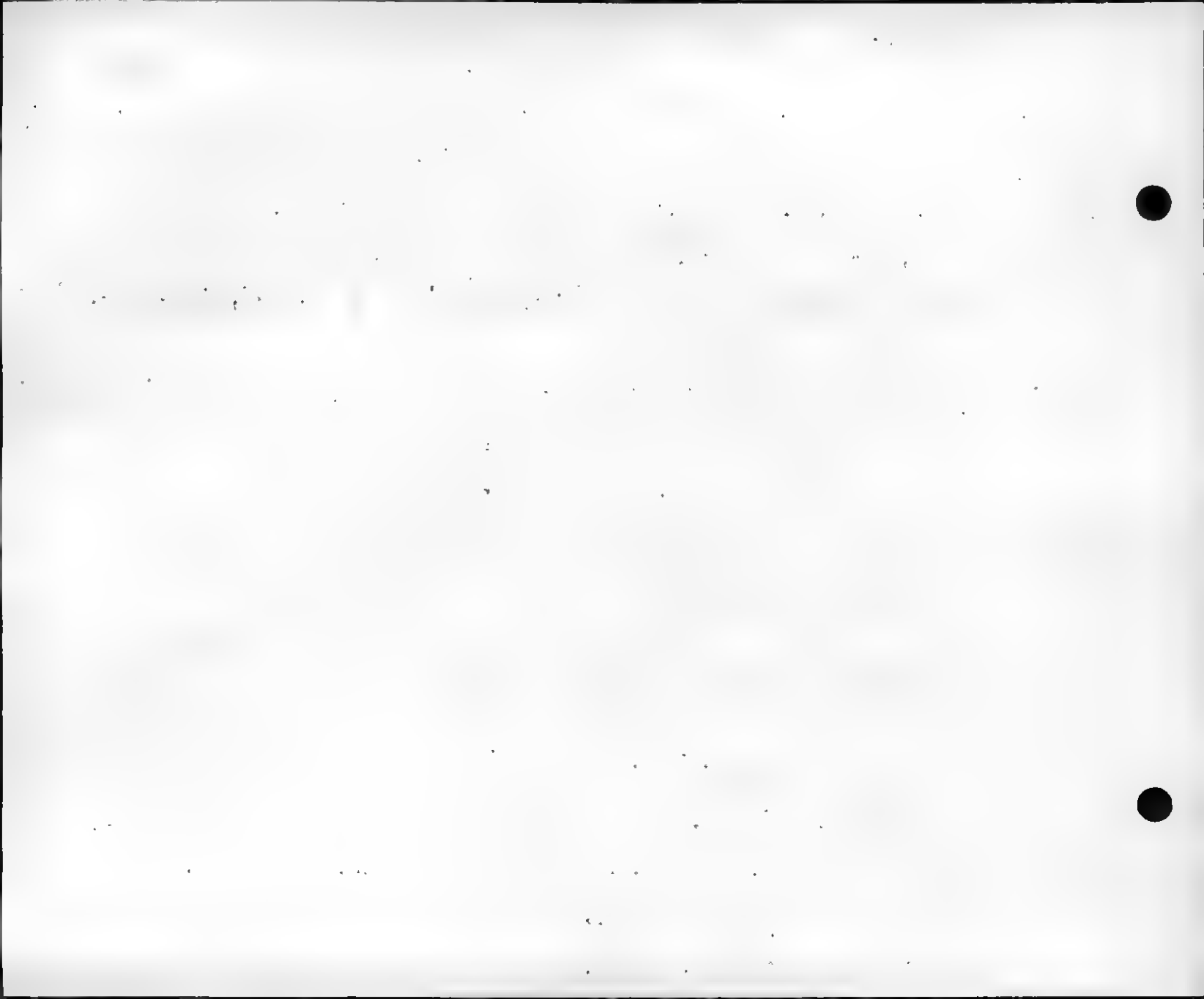
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VR A15 (4)
30M REV 1/68

MEDICAL CERTIFICATION

1 DECEASED-NAME (Type or print)				First		Middle		Last		2a. DATE OF DEATH		2b. HOUR					
Edward Lawrence Benhoff										Month February Day 24 Year 1968		1:00 A.M.					
3 SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN					
Male		White		4-9-1888				79 YRS.									
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH											
Baltimore, Md.		U.S.A.				Balto. Md.											
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY							
Towson, Maryland		St. Joseph Hospital				Retrolman - retired											
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before address on) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER									
Florida xxxxxx				Ft. Lauderdale xxxxxx		NO <input checked="" type="checkbox"/>		4579 N.W. 16th, Torer. xxxxxx									
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME													
First Middle Last				First Middle Last													
Adam Benhoff				Mary													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.				17 INFORMANT									
no				215-22-1106				Glen Arm, Md. Rd. Lawrence J. Benhoff Box 610 Harford									
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage																	
DUE TO, OR AS A CONSEQUENCE OF																	
(b) Artio Sclerotic Cardio Vascular Disease																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
				HOUR A.M. Month Day Year P.M. 19													
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)				21f. LOCATION		Street or R.F.D. No.		City or Town		County		State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>																	
22a. I certify that (I) (this hospital) attended the deceased from Feb. 18th, 1968, to Feb. 24, 1968, that (I) (we) last saw the deceased alive on Feb. 24th, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE												22c. DATE SIGNED					
Alexis S. Sayoc M.D.												2-24-68					
22d. PHYSICIAN'S NAME (Type)												22e. ADDRESS					
Alexis S. Sayoc, M.D.												7620 York Rd., Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town)		(County)		(State)					
Burial		2/27/68		Oaklawn Cem.				Balto.				Md.					
24. FUNERAL DIRECTOR								25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Leonard J. Ruck Inc. Balto. Md.								DATE FEB 26 1968		J. Charles Judge							



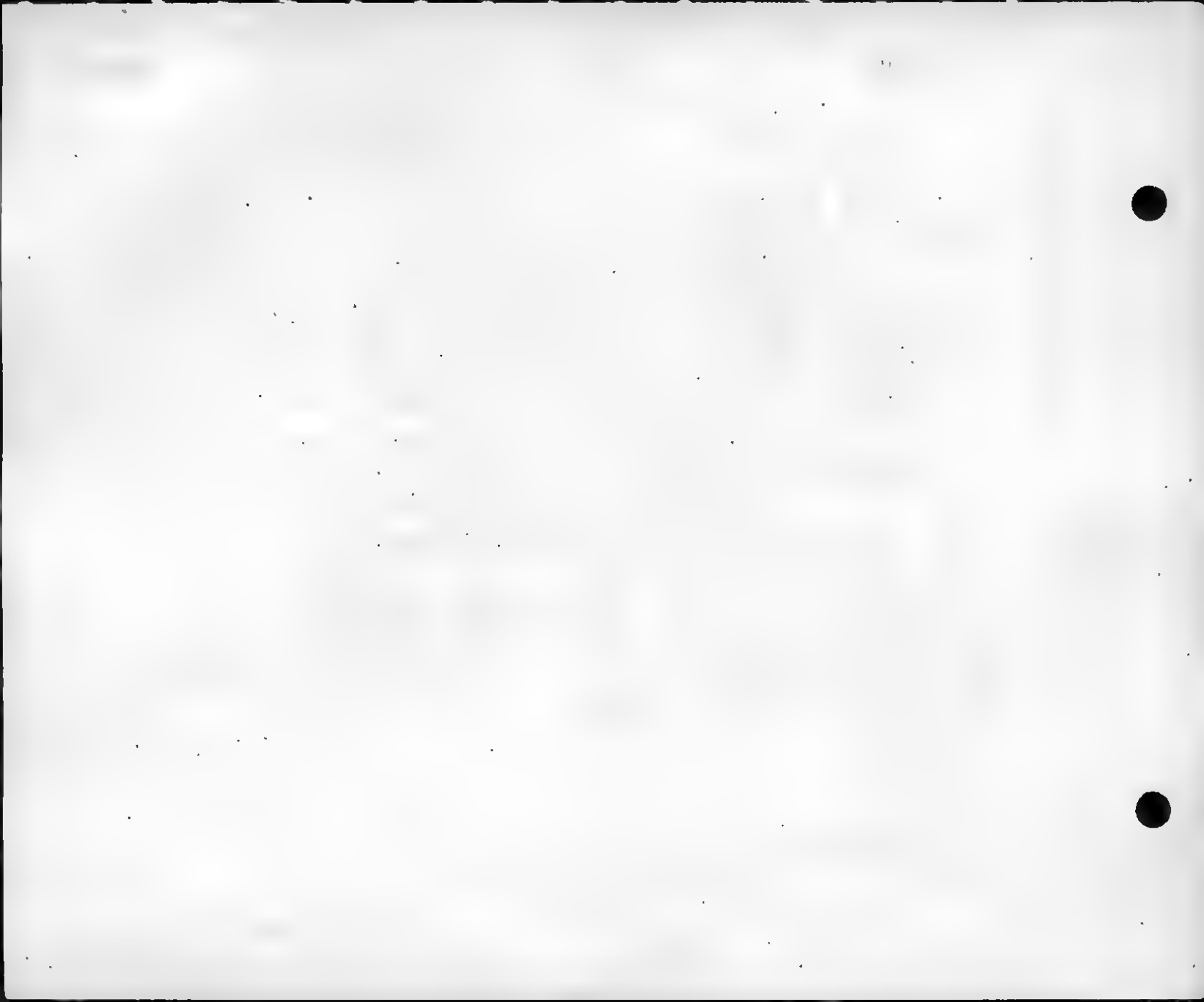
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TOWSON c. LENGTH OF STAY IN 1b 3 WKS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) TOWSON NURSING HOME		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 534 N GLOVER ST e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANK Middle JOHN Last BIEBEL		4. DATE OF DEATH Month FEB Day 29 Year 1968	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 17 1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED LABOR		10b. KIND OF BUSINESS OR INDUSTRY ACME BOX CO	9. AGE (In years last birthday) 72 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) BALTIMORE MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALOYSIUS BIEBEL		14. MOTHER'S MAIDEN NAME HILDEGARD FISCHER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WORLD WAR I		16. SOCIAL SECURITY NO. 213-035788	
17. INFORMANT WILLIAM L BIEBEL		Address 534 N GLOVER ST	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Decompensative Cardio Vascular Disease DUE TO (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb 10, 1968 to Feb 29, 1968 , that (I) (we) last saw the deceased alive on Feb 29, 1968 , and that death occurred at 1:45 AM , from the causes and on the date stated above.			
22a. SIGNATURE Laurence C. Post		22b. DATE SIGNED 2/29/68	
22c. PHYSICIAN'S NAME (Type) LAURENCE C. POST		22d. ADDRESS 6805 YORK ROAD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF MAR 2 1968	23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER CEM	23d. LOCATION (City, town or county) (State) 4430 BELAIR RD MD
24. FUNERAL DIRECTOR DIPPEL BROS INC 1800 E LOMBARD ST		25a. REC'D BY REGISTRAR MAR 1 1968 DATE	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

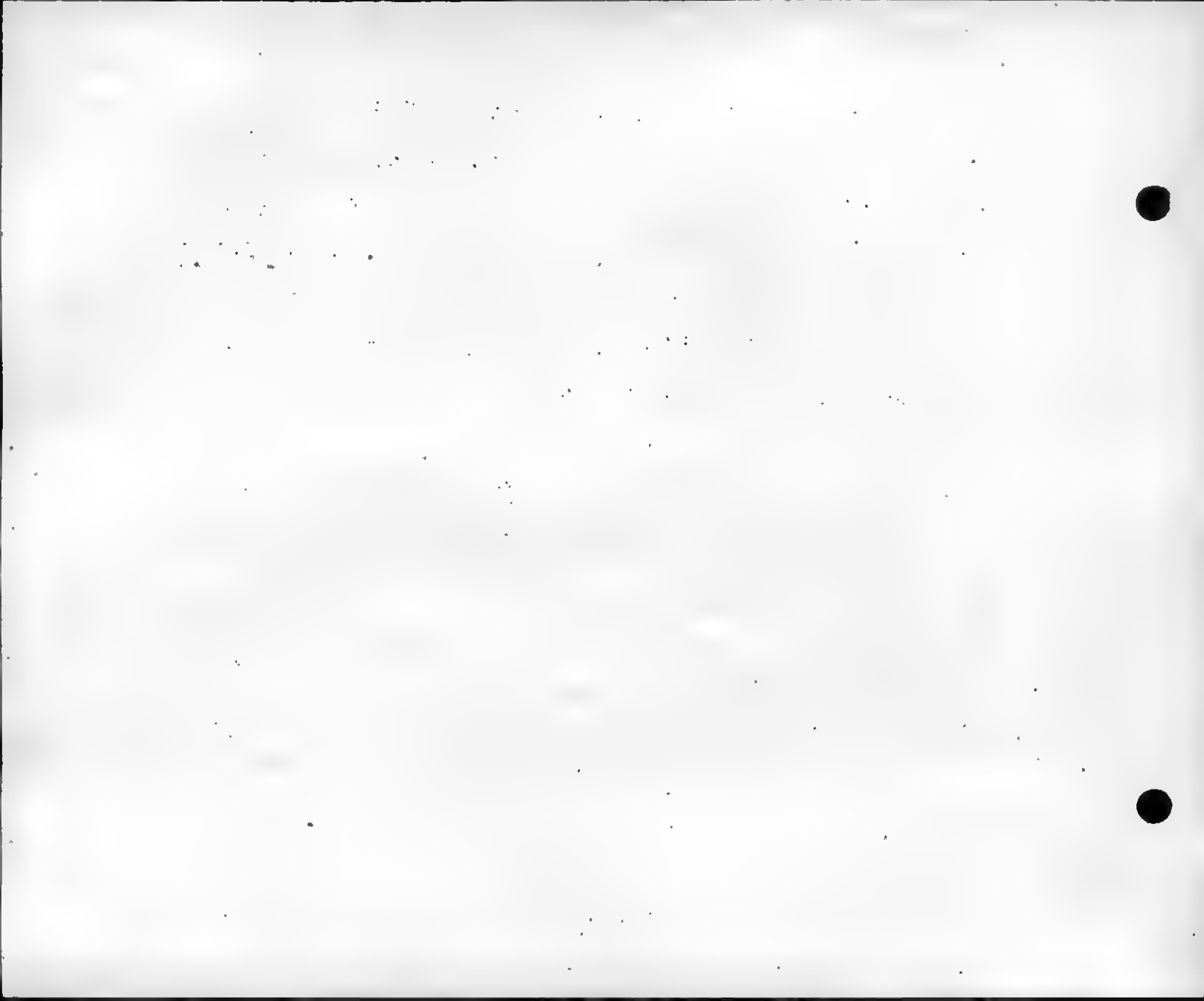
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 2 and 3, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR				
EARL CLAIRBORNE BLANKENSHIP						Month 2 Day 3 Year 68			1:45 PM				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
MALE		CAU		6-29-'08			59 YRS.		MONTHS DAYS		HOURS MIN		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md	
NORFOLK, VA.			U.S.A.						BALTIMORE				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if not in that occupation)			12b. KIND OF BUSINESS OR INDUSTRY				
TOWSON			GREATER BALTO. Medical Center President of Baltimore Co.										
13a. USUAL RESIDENCE (Where deceased lived, if institution Res. since before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INS. OF CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER	
MARYLAND			BALTIMORE			TOWSON			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			1601 RUXTON COURT	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last										
RUFUS BLANKENSHIP			CLAIRBORNE, Francis										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give number of years of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address				
NA NA			213-10-1770			CHART							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART 1 DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>expanding tumor</u>													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic carcinoma following removal</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) <u>hypertension</u>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
1													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 3 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Jan 23, 1968, to Feb 3, 1968, that (I) (we) last saw the deceased alive on Feb 3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Francis C. Guiton</u>						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED Feb 3, 1968				
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			2/7/68			Woodlawn Cemetery			Woodlawn Maryland				
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR DATE FEB 9 1968			25b. REGISTRAR'S SIGNATURE <u>Wm. Cook-Brooks</u>				
Wm. Cook-Brooks Towson 1050 York Rd. 21204													



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Page 2M3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print) JAMES WILSON BLIZZARD JR			First Middle Last			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Feb Day 20 Year 1968			2b HOUR 7:30 PM		
3 SEX M		4 RACE W		5 DATE OF BIRTH 6-7-53		6 AGE (in years last birthday) 14 YRS		IF UNDER 1 YEAR MONTHS DAYS		F UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Woodensburg, Md			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH BALTIMORE Md		
1d CITY OR TOWN OF DEATH Towson			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md			13b COUNTY Baltimore			13c CITY OR TOWN Sparks			3d INSIDE CITY, AM 15? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME First Middle Last James W. Blizzard, Jr.			15 MOTHER'S MAIDEN NAME First Middle Last Shirley Heland			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b SOCIAL SECURITY NO No		
17 INFORMANT James W. Blizzard, Sr.			ADDRESS Sparks, Md			18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SHOTGUN WOUND, RIGHT UPPER THORAX			DUE TO, OR AS A CONSEQUENCE OF (b)			DUE TO, OR AS A CONSEQUENCE OF (c)			3 HRS		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 9120			19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			2d. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year 9:30 AM 2/20 1968			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Accidental discharge of Shotgun			21d LOCATION Street or R.F.D. No City or Town County State WHEELER LANE SPARKS BALTO MD		
21a INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK			21b PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Accidental discharge of Shotgun			21d LOCATION Street or R.F.D. No City or Town County State WHEELER LANE SPARKS BALTO MD		
22a I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			22b DATE SIGNED 2 20 68			22c SIGNATURE William A. Pillsbury M.D.			22d SIGNATURE Charles Judge		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE Feb. 23, 1968			23c NAME OF CEMETERY OR CREMATORY Mt. Eilead			23d LOCATION (City or Town) (County) (State) Woodensburg, Balto. Md.		
24 FUNERAL DIRECTOR Wm. Cook-Brooks			ADDRESS Towson, Towson, Md.			25a REC'D BY REGISTRAR FEB 23 1968			25b REGISTRAR'S SIGNATURE Charles Judge		



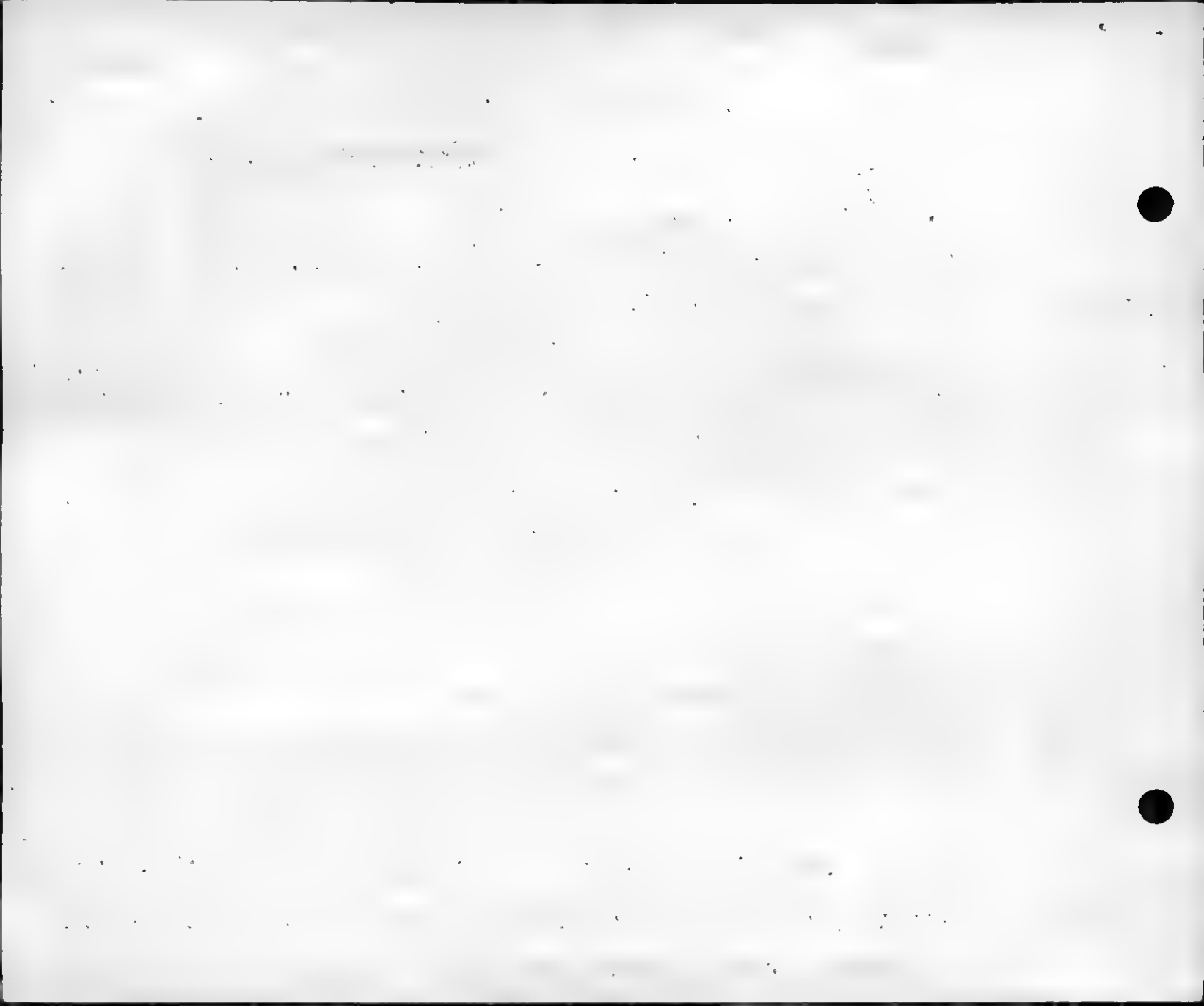
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR				
MORRIS			BLOCK			Month 2 Day 28 Year 68			4:15 AM				
3 SEX		4 RACE		5. DATE OF BIRTH			6 AGE (In years last b/tday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		
MALE		WHITE		XXXXXXXXXX			XX XX 68 YRS.						
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
RUSSIA			U.S.A.						BALTIMORE			Md	
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY	
RANFALLS TOWN				BALTIMORE CO. 540 Reed Court Rd. WOHLMUTH CO.				TAILOR					
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER	
Md.			BALTIMORE			BALTIMORE			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			3653 Essex Rd #7	
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
First Middle Last			First Middle Last										
ISRAEL			BLOCK			IDA			STEIN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17 INFORMANT			Address				
NO			212-03-2602			DR. PHILIP L. BLOCK,			2709 GLEN AVE.			#21215	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Metastatic Carcinoma													
DUE TO, OR AS A CONSEQUENCE OF													
(b) Carcinoma of prostate													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.				City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 2-26, 1968, to 2-28, 1968, that (I) (we) last saw the deceased alive on 2-28-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE												22c. DATE SIGNED	
Gracito V. Patricio												2/28/68	
22d. PHYSICIAN'S NAME (Type)												22e. ADDRESS	
GRACITO V. PATRICIO												BALTIMORE COUNTY GENERAL HOSPITAL	
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
BURIAL		2-29-68		AGUDAS ACHIM ANSHE SFARD, BALTIMORE, MARYLAND									
24. FUNERAL DIRECTOR				ADDRESS				ROAD MAR 1 1968		25b. REGISTRAR'S SIGNATURE			
SOL LEVINSON & BROS., 6010 REISTERSTOWN													

MEDICAL CERTIFICATION

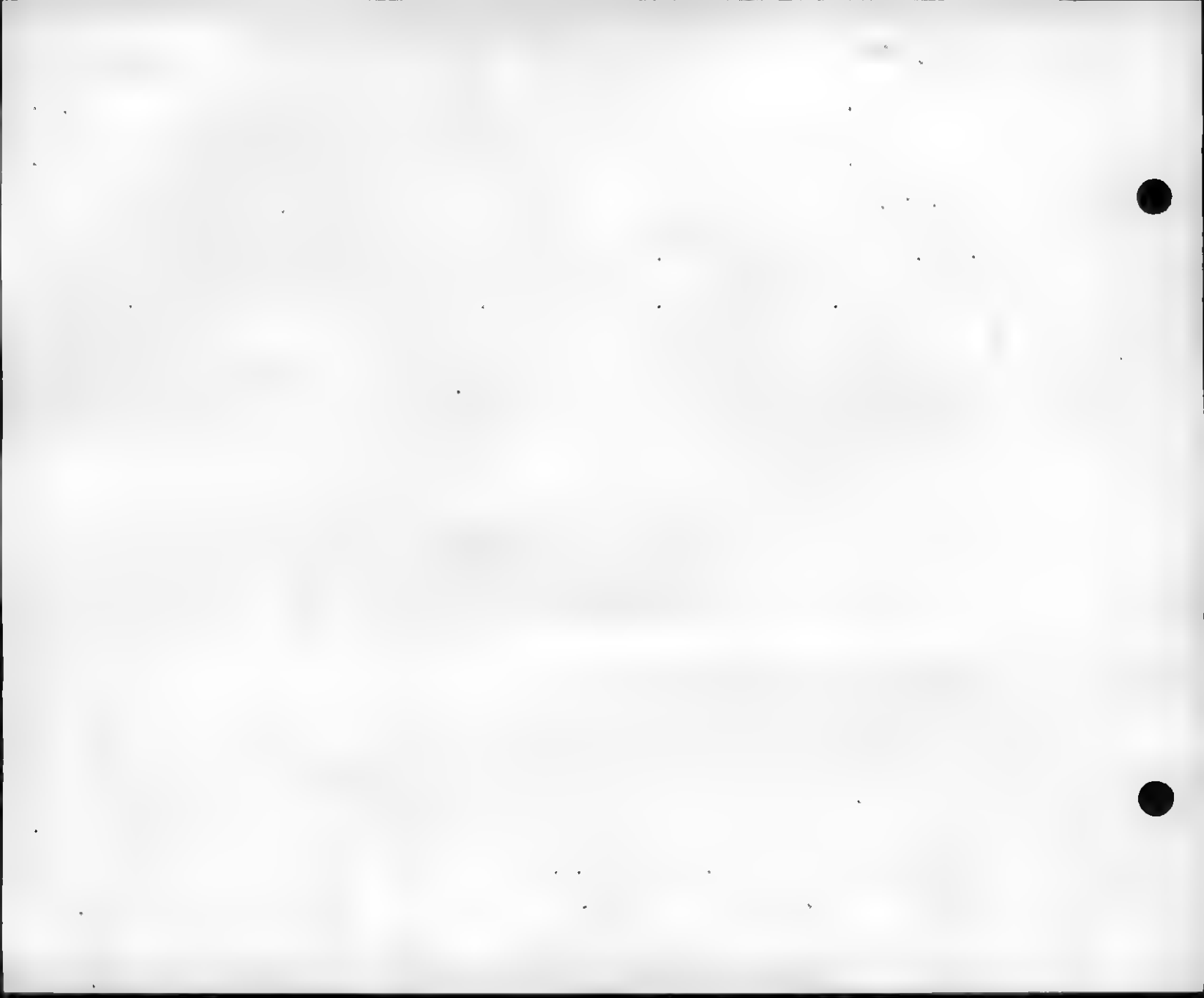


FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or Print)			First			Middle			Last		
AUDREY			NELLIE			BODE			2a DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Month Day Year 2 23 19 68 10:40		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
Female		White				55 YRS.					
7a BIRTHPLACE (State or foreign country)				7b CITIZEN OF WHAT COUNTRY?				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
Balto., Md.				USA				9 COUNTY OF DEATH Balto. Md.			
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)			
Balto.				St. Joseph Hospital				homemaker			
13a USUAL RESIDENCE (Where deceased lived if institution on residence before admission) STATE				13b COUNTY				13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Md.				Balto.				Balto.		7800 Ruxway Rd.	
14 FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last							
Carl A. Clemson				Nellie C.							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO.				17 INFORMANT ADDRESS			
no								LeRoy W. Bode 7800 Ruxway Road #4			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Subarachnoid hemorrhage											
DUE TO, OR AS A CONSEQUENCE OF (b) Ruptured aneurysm											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
330x											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day Year HOUR A M P M 19				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)				21f LOCATION Street or R.F.D. No City or Town County State			
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect on <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Edward F. Wilson				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED February 24, 1968			
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
23a BURIAL, CREMATION REMOVAL (Specify) burial				23b DATE 2/26/68		23c NAME OF CEMETERY OR CREMATORY Parkwood				23d LOCATION (City or Town) (County) (State) Balto., Md.	
24 FUNERAL DIRECTOR Mitchell-Wiedefeld Home 6500 York Road Balto., Md. 21212						25a REC'D BY REGISTRAR DATE FEB 29 1968		25b REGISTRAR'S SIGNATURE			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																	
1. DECEASED NAME (Type or Print) Matthew			First F.			Middle Bolties			Last								
2a. DATE KNOWN OF DEATH		Month Feb.		Day 3		Year 1968		2b. HOUR		7:30 P.M.							
3 SEX Male		4 RACE White		5 DATE OF BIRTH June 28, 1922		6 AGE (In years last birthday) 45 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN 0							
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Baltimore								
10 CITY OR TOWN OF DEATH Baltimore			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 508 Fairview Avenue			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Road Foreman			12b. KIND OF BUSINESS OR INDUSTRY Baltimore Co.								
13a. USUAL RESIDENCE (Where deceased lived, if institution on residence before admission) STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 508 Fairview Ave.						
14 FATHER'S NAME First Frederick			Middle Bolties			Last			15 MOTHER'S MAIDEN NAME First Jenny			Middle Sattler			Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16b. SOCIAL SECURITY NO 213-16-5077			17. INFORMANT (Wife) Mrs. Elizabeth Bolties			ADDRESS Balto. Md. 21224								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertension C-V-N disease DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 20												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 443X																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? N/A			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year 19 P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town			County		State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE Melvin B. Davis			EXAMINER'S NAME (Type) Melvin B. Davis			M.D. M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> 6800 Morningside Ave.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 22b. DATE SIGNED 2/3/68					
23a. BURIAL CREMATION REMOVAL (Specify) Burial			23b. DATE 2/7/68			23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery			23d. LOCATION (City or Town) Baltimore, Md.			(County) (State)					
24 FUNERAL DIRECTOR John J. Duda			ADDRESS 7922 Wise Ave. Dundalk, Md.			25a. REC'D BY REGISTRAR FEB 9 1968			25b. REGISTRAR'S SIGNATURE [Signature]								

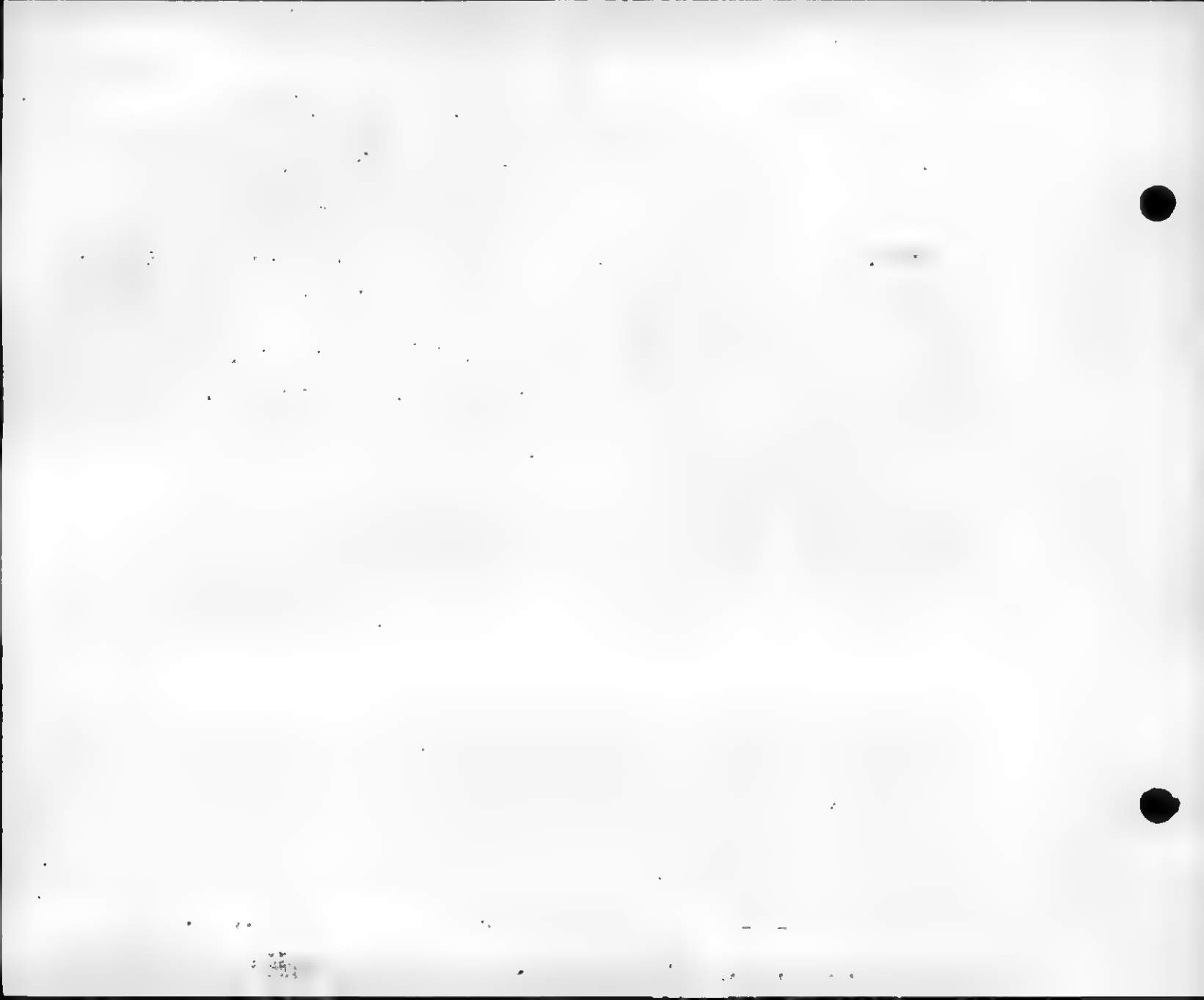
11153

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) VINCENT		First Middle Last		2a. DATE OF DEATH Month Day Year February 24, 1968		2b. HOUR 12:45 PM	
3 SEX Male		4 RACE White		5. DATE OF BIRTH August 20, 1913		6. AGE (In years last birthday) 54 YRS	
7a. BIRTHPLACE (State or foreign country) Baltimore		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) Restaurateur		12b. KIND OF BUSINESS OR INDUSTRY Restaurant	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission), STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 5218 McFaul Road #6		14. FATHER'S NAME First Middle Last Paul Bonolis		15. MOTHER'S MAIDEN NAME First Middle Last Anna Scuto			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO		17. INFORMANT Paul Bonolis, 5218 McFaul Rd.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that to (this hospital) attended the deceased from February 24, 1968 , to February 24, 1968 , that it (we) last saw the deceased alive on February 24, 1968 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, it (we) (did) not view the body after death.							
22b. SIGNATURE <i>Jaime Singzon</i>		22c. PHYSICIAN'S NAME (Type) Jaime Singzon, M.D.		22d. ADDRESS 7620 York Road, Towson 4, Md.		22e. DATE SIGNED February 24, 1968	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-27-68		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION (City or Town) (County) (State) Balto., Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc., 5305 Harford Rd.				25a. REC'D BY REGISTRAR FEB 26 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

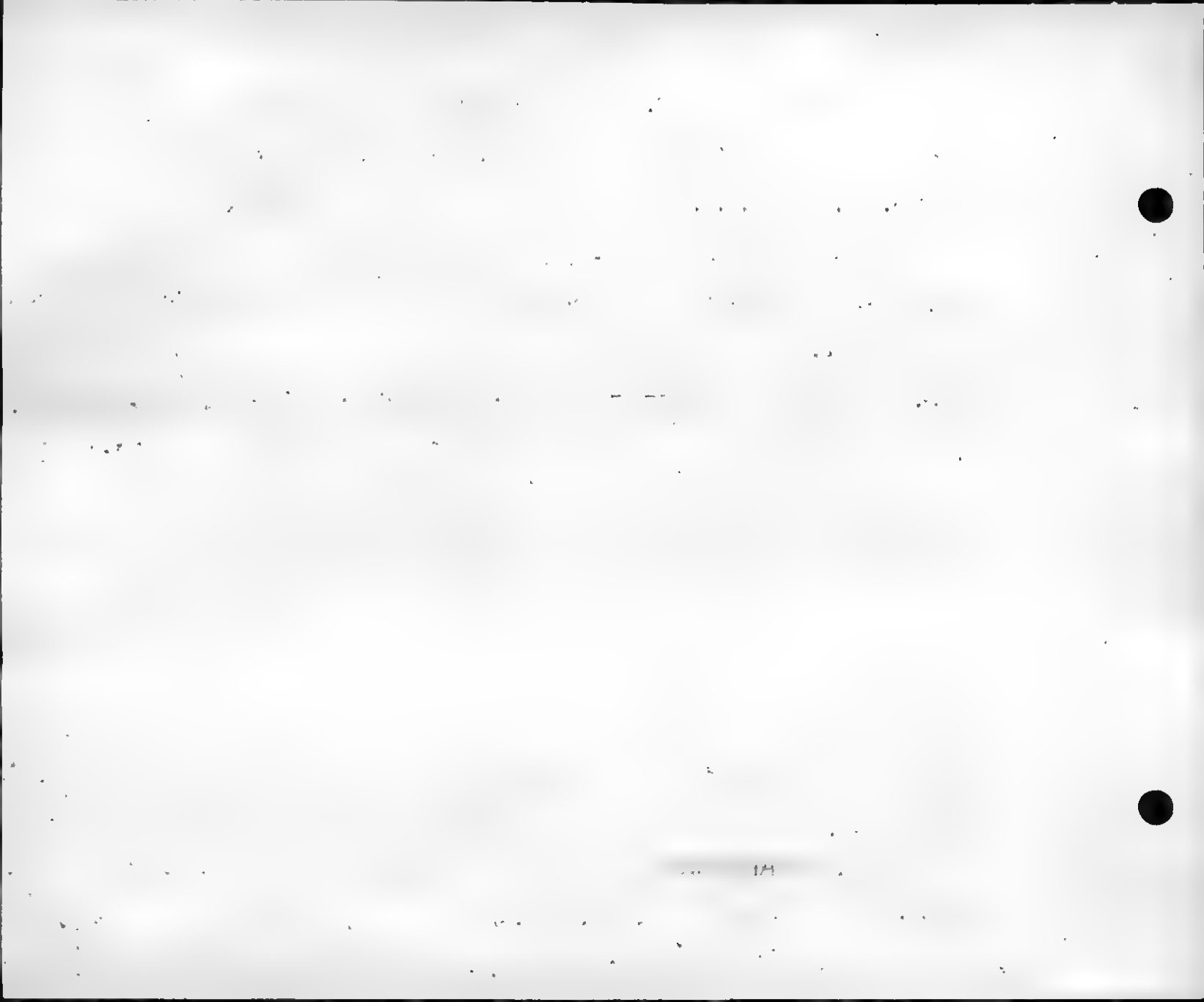


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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) Robert			First F. Middle Bonsall Last			2a. DATE OF DEATH Feb Month 14 Day 1968 Year			2b. HOUR 7 a.m.		
3 SEX Male		4. RACE White		5. DATE OF BIRTH July 19, 1926			6. AGE (in years last birthday) 41 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.					
10. CITY OR TOWN OF DEATH Randallstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Box 355 Marriottsville Rd			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Manager			12b. KIND OF BUSINESS OR INDUSTRY Restuarant		
13a. USUAL RESIDENCE (Where deceased lived, if address) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Randallstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Box 355 Marriottsville Rd			
14. FATHER'S NAME First James J. Middle Bonsall Last			15. MOTHER'S MAIDEN NAME First Sarah Middle Wallace Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) yes		(If yes give war or dates of service.) WWII		16b. SOCIAL SECURITY NO. 219-16-7787		17. INFORMANT Mrs. Catherine B. Bonsall			Address Box 355 Marriottsville Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) 3 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 Month 14 Day 1968 Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State 					
22a. I certify that (I) (this hospital) attended the deceased from 2-14-1968 , to 2-14-1968 , that (I) (we) last saw the deceased alive on 2-14-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Emilio Valle Cavero						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-14-68			
22d. PHYSICIAN'S NAME (Type) Dr. EMILIO VALLE CAVERO						22e. ADDRESS Liberty Rd Randallstown, Md					
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE 2/17/68		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION (City or Town) Baltimore (County) Maryland (State) 					
24. FUNERAL DIRECTOR Spring Byers ADDRESS 8728 Liberty Rd Randallstown, Md						25a. REC'D BY REGISTRAR DATE FEB 19 1968		25b. REGISTRAR'S SIGNATURE Charles J. Jones			

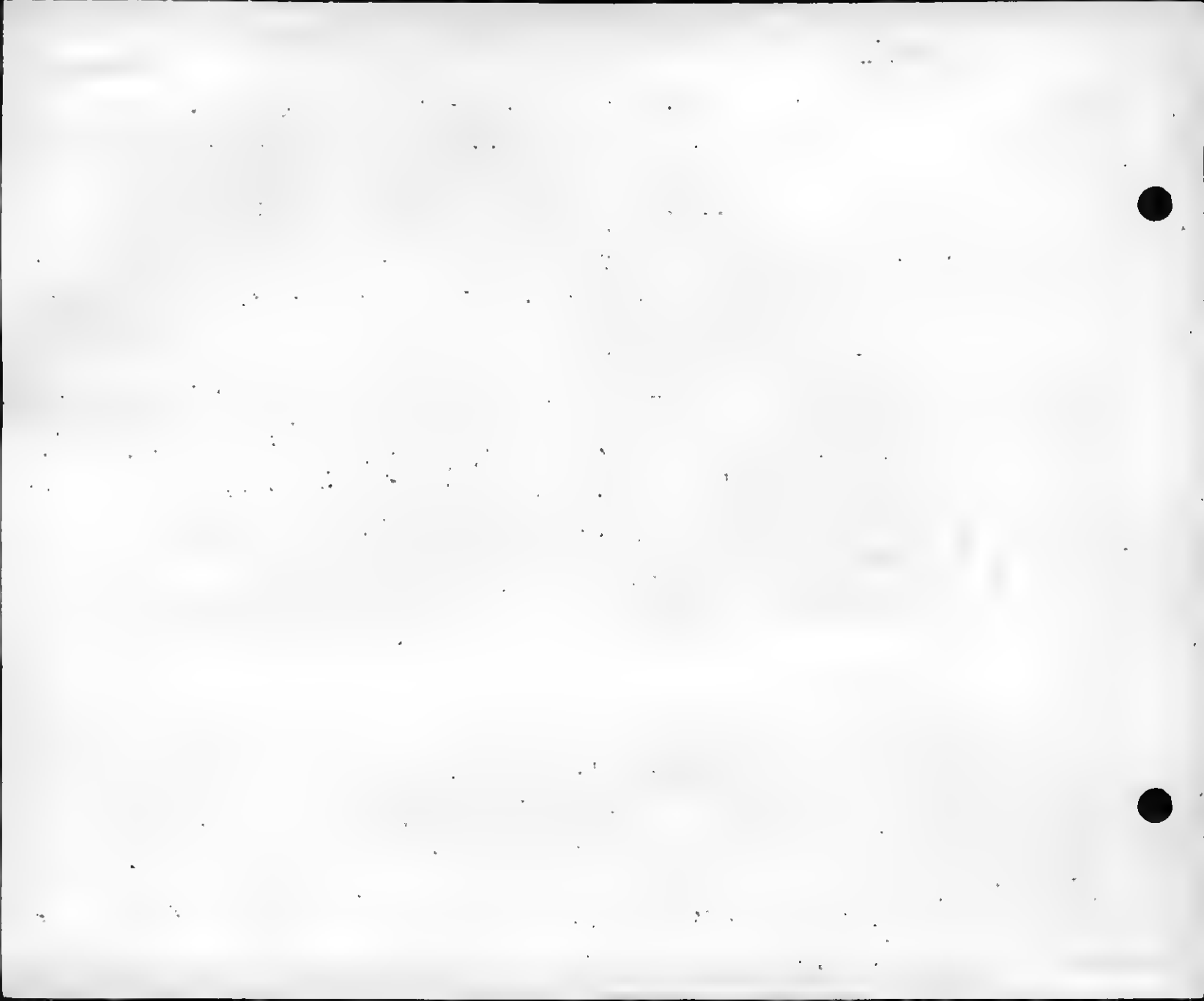


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MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First Carl	Middle William	Last Bornmann	2a. DATE OF DEATH Month Day Year Feb 5 1968		2b. HOUR 2:58 AM
3 SEX Male	4 RACE White	5. DATE OF BIRTH 2/13/02		6. AGE (in years last birthday) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md			
10. CITY OR TOWN OF DEATH Rural Baltimore	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Augsburg Home 6811 Campfield Road		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Optician		12b. KIND OF BUSINESS OR INDUSTRY Optical Co.		
13a. USUAL RESIDENCE (Where deceased lived, if admission) STATE Maryland	13b. COUNTY Pr. George	13c. CITY OR TOWN Hyattsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 403 Greenlawn Drive #201			
14. FATHER'S NAME First Middle Last Louis Bornmann		15. MOTHER'S MAIDEN NAME First Middle Last Emma Deichmiller					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 577-05-3086A	17. INFORMANT Address Paul A. Hauer 6811 Campfield Road 21201				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) (1) <u>Lobar Pneumonia (Rt.)</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arterio Sclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Arterio Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic Brain Syndrome</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH - 5 days - 2 yrs
19a. DATE OF OPERATION <u>None</u>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from Jan 5, 1967, to Feb 4, 1968, that (I) (we) lost saw the deceased alive on Feb 2nd, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Earl L. Chambers M.D.		DEGREE	ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 2/4/68	
22d. PHYSICIAN'S NAME (Type) Earl L. Chambers M.D.		22e. ADDRESS 4108 Liberty Hts Balto. Md					
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE Burial 2/6/68	23c. NAME OF CEMETERY OR CREMATORY St Pauls		23d. LOCATION (City or Town) (County) (State) Chesapeake Md			
24. FUNERAL DIRECTOR J. A. Keenmann		ADDRESS 6067 Hay Rd		25a. REC'D BY REGISTRAR DATE FEB 8 1968		25b. REGISTRAR'S SIGNATURE John J. Judge	



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VR A15 (4)
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <i>First</i> <u>Maria</u> <i>Middle</i> <u>Bossi</u> <i>Last</i>				2a. DATE OF DEATH <u>2</u> Month <u>17</u> Day <u>68</u> Year				2b. HOUR <u>3 P.M.</u>			
3 SEX <u>female</u>		4 RACE <u>white</u>		5 DATE OF BIRTH <u>4-26-1878</u>		6 AGE (In years last birthday) <u>89</u> YRS		F UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS M.N.	
7a BIRTH-PLACE (State or foreign country) <u>Italy</u>		7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <u>Baltimore</u> Md					
10 CITY OR TOWN OF DEATH <u>Lutherville</u>				11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <u>578 Towson Ave</u>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>housewife</u>		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <u>Maryland</u>		13b COUNTY <u>Baltimore</u>		13c CITY OR TOWN <u>Lutherville</u>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <u>578 Towson Ave.</u>			
14. FATHER'S NAME <i>First</i> <u>Pasquale</u> <i>Middle</i> <u>BRESCA</u> <i>Last</i>				15. MOTHER'S MAIDEN NAME <i>First</i> <u>Carmela</u> <i>Middle</i> <u>Towson</u> <i>Last</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>no</u> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <u>213-09-8884</u>		17 INFORMANT <u>Dava M. Powder (daughter)</u> Address <u>578 Towson Ave. Lutherville</u>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5-10 min.</u> <u>3 years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>1963</u> to <u>1968</u> , that (I) (we) last saw the deceased alive on <u>Feb 12</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <u>James R. Powder M.D.</u> DEGREE <u>M.D.</u> ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <u>2-17-68</u>							
22d. PHYSICIAN'S NAME (Type) <u>James R. Powder</u>				22e ADDRESS <u>2 East Road St Balto 21202</u>							
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2/20/68</u>		23c NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>					
24. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook-Brooks Towson 1050 York Rd. 21204</u>				25a REC'D BY REGISTRAR DATE <u>FEB 20 1968</u>		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>					

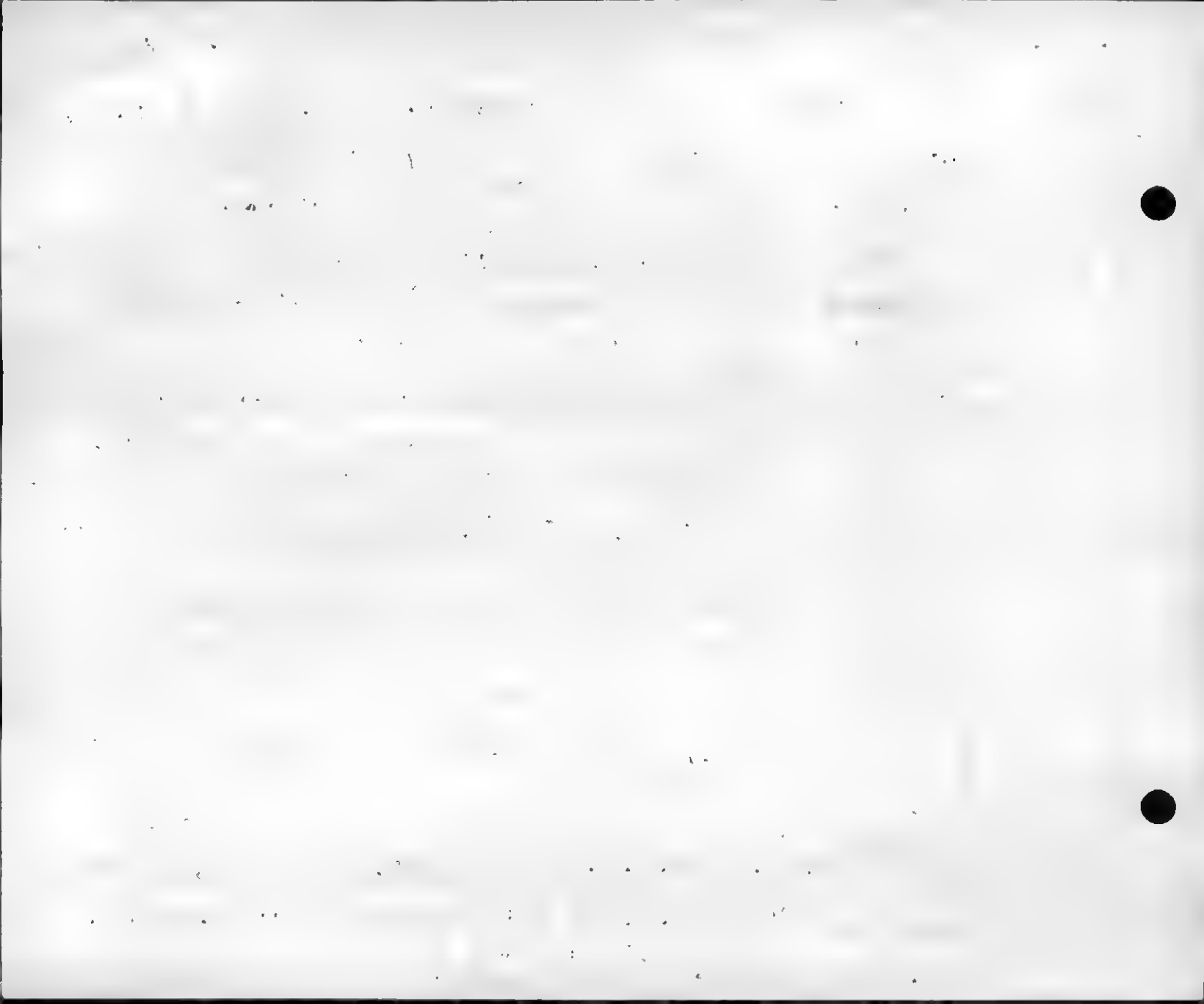
MEDICAL CERTIFICATION



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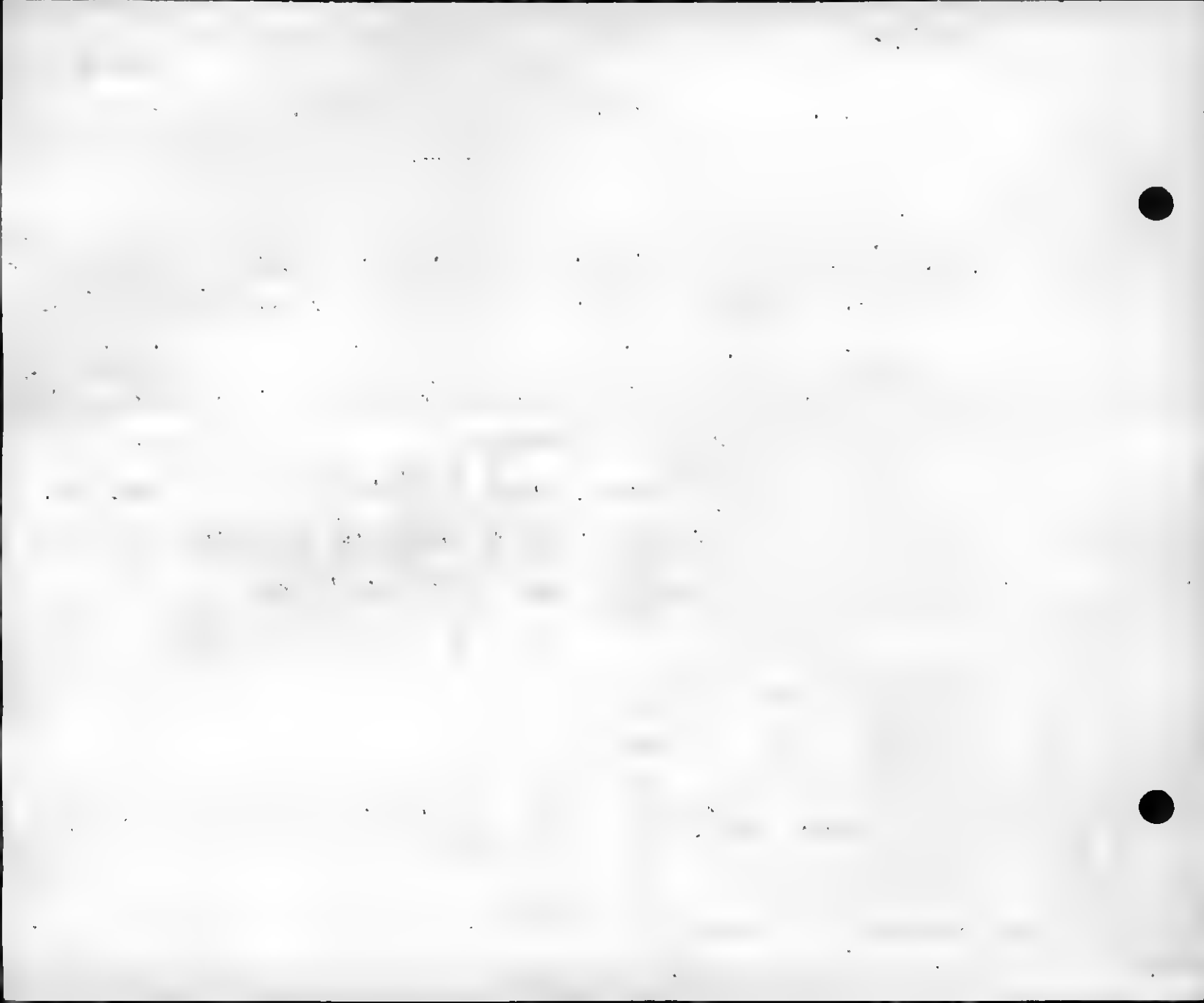
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) GASPER			First Middle Last BOTTEON SR.			2a. DATE OF DEATH Month Day Year FEBRUARY 10 1968			2b. HOUR 9:30 AM		
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 9/20/87			6. AGE (In years last birthday) 80 YRS		
7a. BIRTHPLACE (State or foreign country) ITALY			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE Md		
10. CITY OR TOWN OF DEATH FORT HOWARD			11. NAME OF HOSPITAL OR INSTITUTION (If patient in hospital give street address) HOSPITAL VETERANS ADMINISTRATION			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) BRICKLAYER			12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE MARYLAND			13b. COUNTY BALTIMORE			13c. CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Middle Last JOHN BOTTEON			15. MOTHER'S MAIDEN NAME First Middle Last MARY BETTO								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> (If yes give war or dates of service) WW I			16b. SOCIAL SECURITY NO. 212 16 9676			17. INFORMANT Address CLINICAL RECORDS VA HOSPITAL FT HOWARD, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Infarcts DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis generalized										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days months years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I (this hospital) attended the deceased from 1/25/68 , 19____, to 2/10/68 , 19____, that I (we) last saw the deceased alive on 2/10/68 , 19____, and that in MD (our) opinion death occurred on the date and hour and from the causes stated above. I (we) did not view the body after death.											
22b. SIGNATURE Mario J. Quiros									22c. DATE SIGNED 2/11/68		
22d. PHYSICIAN'S NAME (Type) MARIO J. QUIROS, M. D.									22e. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND		
23a. BURIAL CREMATION, REMOVAL (Specify) Burial			23b. DATE 2/14/68			23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		
24. FUNERAL DIRECTOR John E. Duda Funeral Home			ADDRESS 7922 Wise Avenue			25a. REC'D BY REGISTRAR DATE FEB 14 1968			25b. REGISTRAR'S SIGNATURE		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Robert Thomas Botts			2a. DATE OF DEATH Month Feb. Day 11 Year 1968		2b. HOUR M
3. SEX Male	4. RACE Whit	5. DATE OF BIRTH 11-11-22		6. AGE (In years last birthday) 45 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore Md		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Balto. County Gen.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) GAS STATION	12b. KIND OF BUSINESS OR INDUSTRY ENTER RICHARD KANSEN	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Baltimore	13c. CITY OR TOWN Reisterstown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 412 Sacred Heart Lane	
14. FATHER'S NAME First Middle Last Robert T. Botts			15. MOTHER'S MAIDEN NAME First Middle Last Sarah Cochrane		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) none		16b. SOCIAL SECURITY NO. 220-14-7607	17. INFORMANT MRS. SHIRLEY BOTTS, 412 SACRED HEART LANE, REISTERSTOWN MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADRENAL INSUFFICIENCY 162.1 DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC TUMOR TO ADRENALS DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMA OF LUNG (POST COBALT) WITH METASTASES					APPROXIMATE INTERVAL: BETWEEN ONSET AND DEATH DAYS - WEEKS - MONTHS MONTHS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) CONGESTION - FOCAL HEMORRHAGE AND FIBROSIS OF LUNGS					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Simon Call MD				22c. DATE SIGNED 2-11-68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE FEB 14, 1968		23c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE CEMETERY	
24. FUNERAL DIRECTOR Walter J. Simon		23d. LOCATION (City or Town) (County) (State) PIKESVILLE BALTO. MD.		23e. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE FEB 15 1968	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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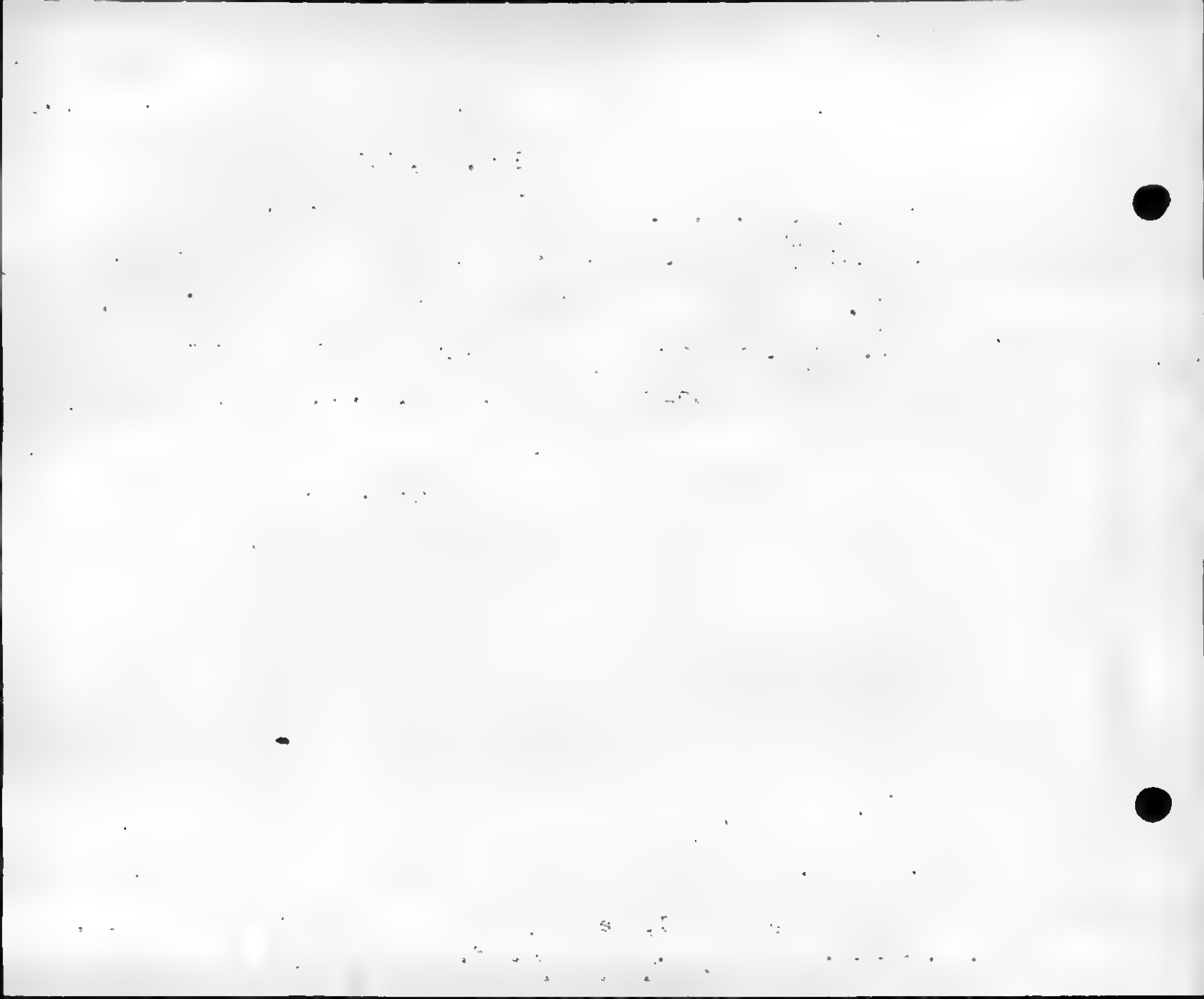


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

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MD. STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
JOHN			SIGLER	BOWMAN	2 Month 7 Day 68 Year		9:30AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
Male		White		Feb. 17, 1898		69 YRS.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Harrisburg, Pa.		U. S. A.				Baltimore Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Balto., Maryland		Greater Balto. Med. Center		Auditor		Social Security Administration		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. STREET AND NUMBER		
Md.				Baltimore		1314 Northview Rd.		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle Last
C. Raymond Bowman					Mary Ella Sigler			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No		172-01-4375		Mrs. Olivette M. Bowman		(Same)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								
PART 1. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) Metastatic carcinoma								
DUE TO, OR AS A CONSEQUENCE OF								
(b) Carcinoma of left kidney (hypernephroma)								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
180x								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from Feb. 2, 1968, to Feb. 7, 1968, that (I) (we) last saw the deceased alive on Feb. 7, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED		22d. ADDRESS				
John E. Adams		Feb. 8, 1968		Greater Baltimore Medical Center				
22e. PHYSICIAN'S NAME (Type)		22f. ADDRESS		22g. DATE SIGNED				
JOHN E. ADAMS, M.D.		Greater Baltimore Medical Center		Feb. 8, 1968				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		2/10/68		Paxtang		Harrisburg, Pa.		
24. FUNERAL DIRECTOR		24a. ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
H. W. Jenkins & Sons Co.		4905 York Rd. Balto. 12, Md.		DATE FEB 8 1968		Charles Judge		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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VR A15ME (5)
10M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or Print) JOHN CLAYTON BRADLEY			First Middle Last			2a. DATE KNOWN OF DEATH Month Feb Day 28 Year 1968			2b. HOUR 2:30 P. M.		
3 SEX M		4 RACE W		5 DATE OF BIRTH 9-6-83		6 AGE (in years and birthday) 84 YRS		F UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Virginia			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE Md		
10. CITY OR TOWN OF DEATH TOWSON			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. JOSEPH Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life or ever retired) Farmer-retired			12b. KIND OF BUSINESS OR OCCUPATION Self Employed		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD			13b. COUNTY BALTO. BALDWIN			13c. CITY OR TOWN BALDWIN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER LongGreen Pike			14. FATHER'S NAME First Middle Last Gaston C. Bradley			15. MOTHER'S MAIDEN NAME First Middle Last Virginia Wickline					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No			16b. SOCIAL SECURITY NO 220-32-2869			17. INFORMANT Family records			ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) TRANSECTION OF SPINAL CORD DUE TO, OR AS A CONSEQUENCE OF (b) DISLOCATION OF SIXTH CERVICAL VERTEBRA DUE TO, OR AS A CONSEQUENCE OF (c) 2 DAYS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. X										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year 2/26 1968 HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) FELL DOWN STAIRS					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) None			21f. LOCATION Street or RFD No BALDWIN City or Town BALDWIN County BALTO. State MD					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE William A. Pillsbury M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 2-28-68		
EXAMINER'S NAME (Type) William A. Pillsbury						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> BALTIMORE			ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE March 2, 1968			23c. NAME OF CEMETERY OR CREMATORY Lake View Memorial Gardens			23d. LOCATION (City or Town) (County) (State) Sykesville, Maryland		
24. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland						ADDRESS			25a. REC'D BY REGISTRAR MAR 4 1968		
						25b. REGISTRAR'S SIGNATURE Charles J. [Signature]					



FOR STATE HEALTH DEPT.

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<div>74140</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div>																	
1. DECEASED NAME (Type or Print)			First			Middle			Last			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 2- 1968			2b. HOJR M		
3 SEX Male			4. RACE White			5. DATE OF BIRTH 3-14-13			6. AGE (in years last birthday) 54 YRS			7c. DATE PRONOUNCED DEAD February 28, 1968			2d. HOUR 11:30 AM		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE								
10. CITY OR TOWN OF DEATH Dundalk			11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp. to give street address) 636 S. 48th Street			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Bargeman			12b. KIND OF BUSINESS OR INDUSTRY Wester Maryland R.R.								
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Dundalk			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 636 S. 48th Street					
14. FATHER'S NAME First Middle Last Herman Bratkowski						15. MOTHER'S MAIDEN NAME First Middle Last Josephine Kaszuba											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no						16b. SOCIAL SECURITY NO (If yes give war or dates of service) 27-14-1862						17. INFORMANT ADDRESS Mary V. Stachurski, sister, 2233 Kentucky Ave. #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Calcific rheumatic aortic stenosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Arteriosclerotic cardiovascular disease</u>																	
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)						21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion an death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <u>Charles S. Springate</u>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED February 29, 1968					
EXAMINER'S NAME (Type) Charles S. Springate, M.D.						ADDRESS (Street, city, town, or county)											
23a. BURIAL CREMATION, REMOVAL (Specify) Burial						23b. DATE 3/2/68						23c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery					
24. FUNERAL DIRECTOR Schimunek Funeral Home 3331 Brehms Lane #13						23d. LOCATION (City or Town) (County) (State) Balto., Md.						23e. REC'D BY REGISTRAR MAR 4 1968					
						23f. REGISTRAR'S SIGNATURE <u>Charles J. Young</u>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

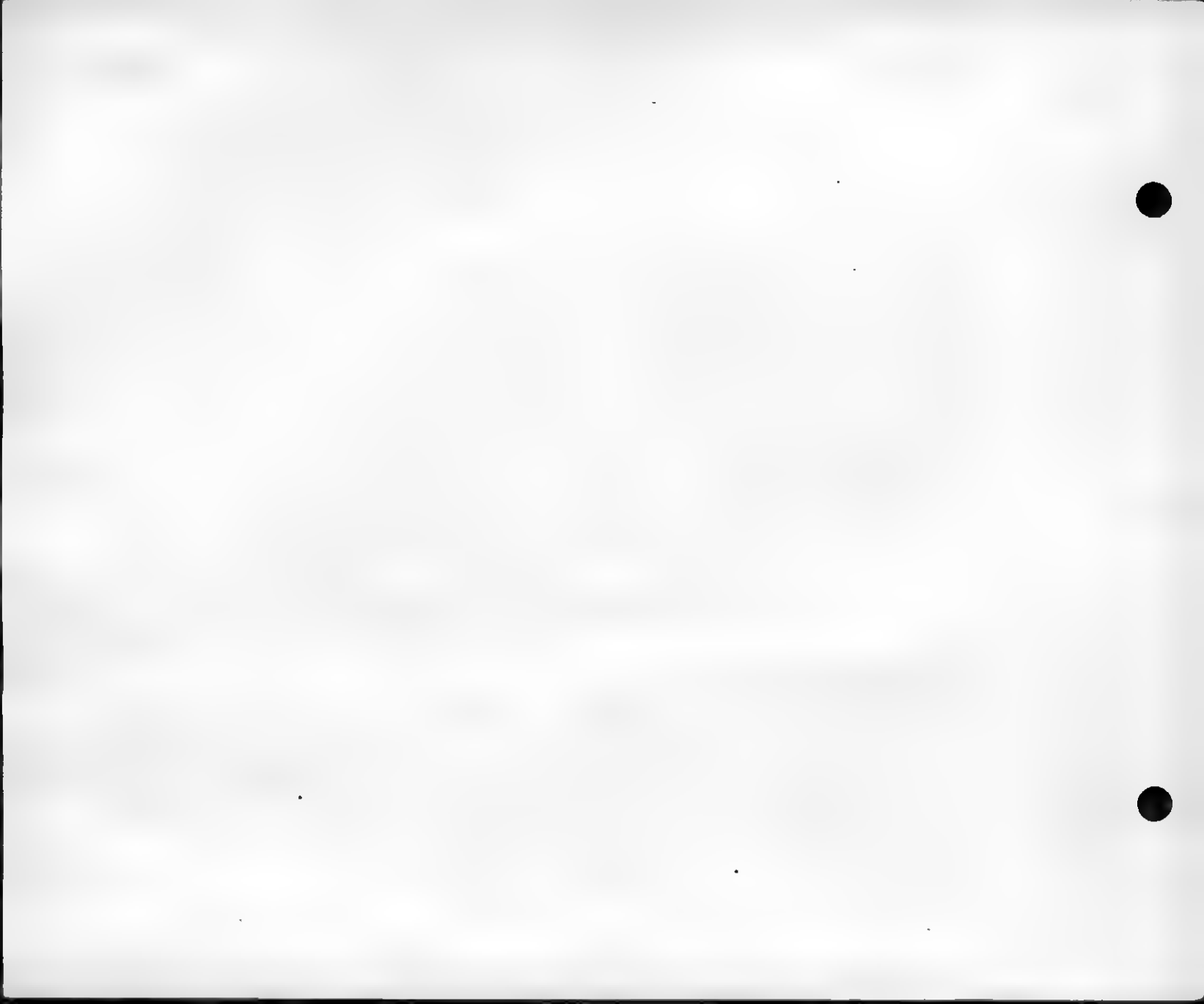
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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>	
c. LENGTH OF STAY in 1b <u>4 weeks</u>		d. STREET ADDRESS <u>Liberty Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Chapel Hill Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MINERVA</u> <u>Virginia</u>		4. DATE OF DEATH <u>February 27, 1968</u>	
5. SEX <u>Female</u> 6. CO. OR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>Feb. 27, 1978</u> 9. AGE (In years last birthday) <u>50</u> yrs.		10. UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Hoffman</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Cromwell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Mr. John E. Brungle</u> Address <u>At Home</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerosis, generalized, severe;</u> <u>4129</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Chronic brain syndrome, ASHD, severe;</u> DUE TO (c) <u>Cardiac failure, grade 4; Cardiac arrest.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1958</u> <u>to</u> <u>2/27/68</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>4200</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1958</u> , <u>19</u> to <u>2/27</u> , <u>1968</u> that (I) (we) last saw the deceased alive on <u>2/27/1968</u> , and that death occurred at <u>9:30 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Howard E. Hall</u> M.D.		22b. DATE SIGNED <u>2/28/68</u>	
22c. PHYSICIAN'S NAME (Type) <u>Howard E. Hall, M.D.</u>		22d. ADDRESS <u>Sykesville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>3-1-68</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Not a list</u>	23d. LOCATION (City or Town) (County) (State) <u>Frederick, Md.</u>
24. FUNERAL DIRECTOR <u>Arthur H. Haight</u> <u>Sykesville, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>MAR 4 1968</u>	



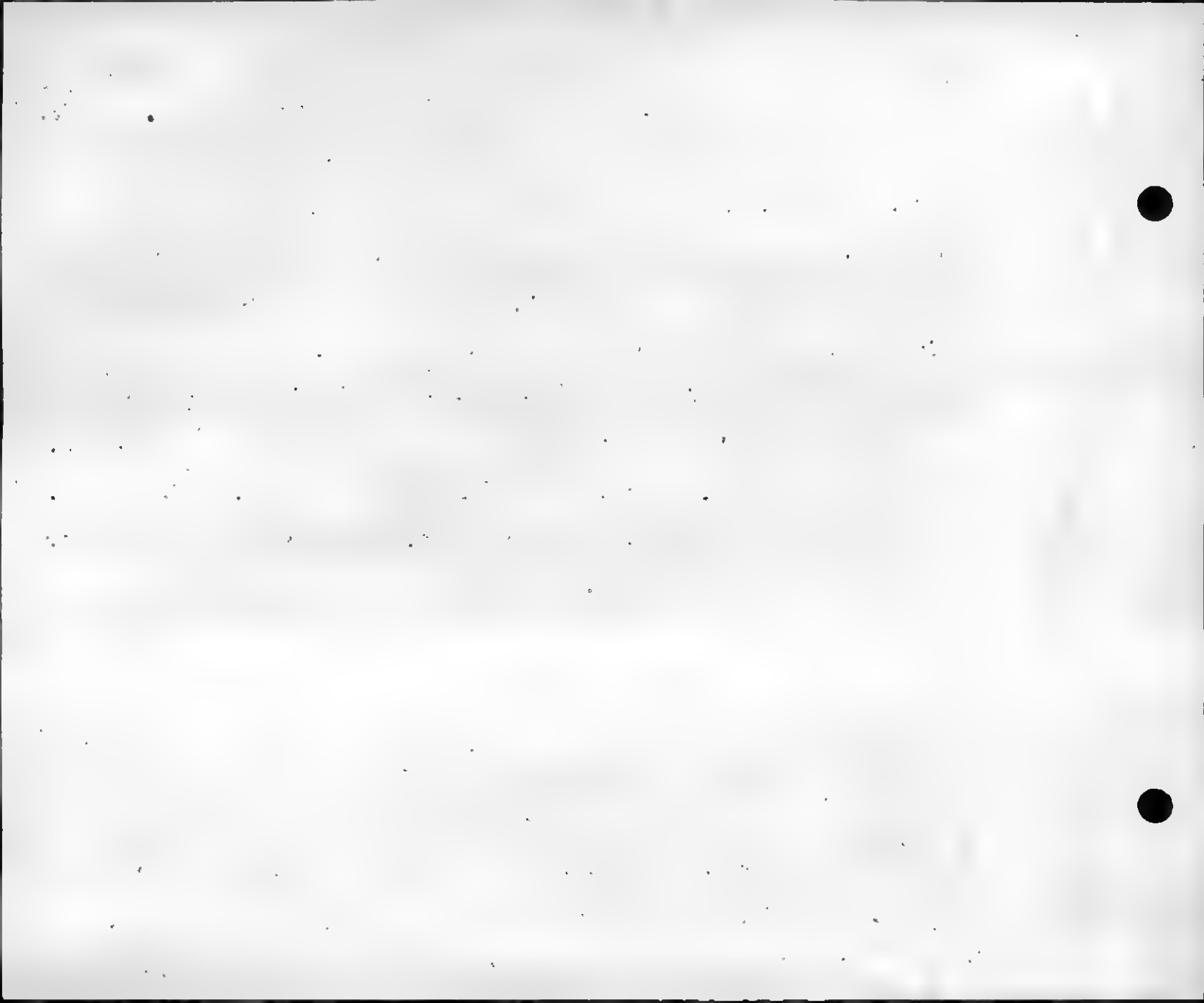
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

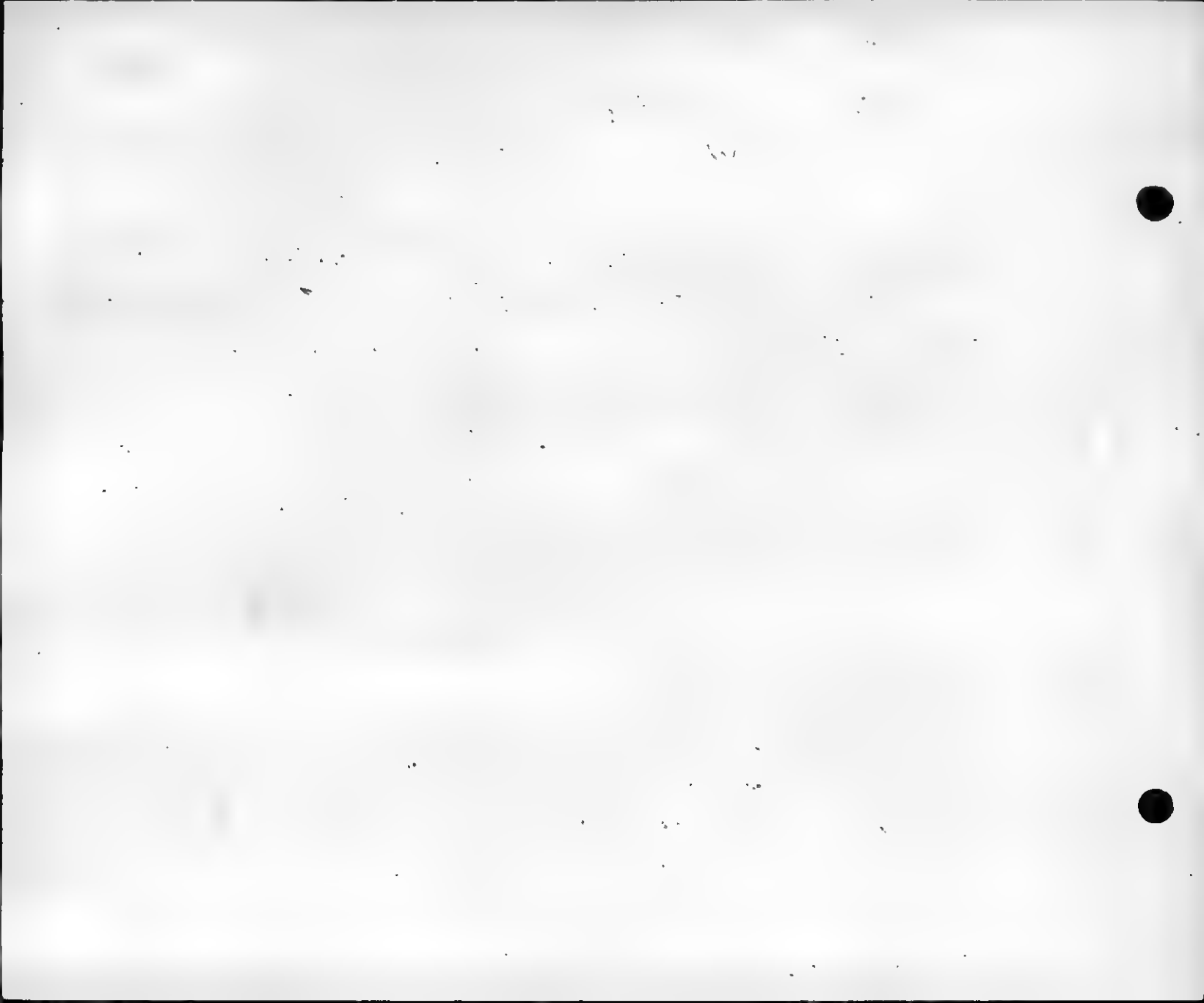
1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR a. 12:30 p.		
Bernard		W.		Brewer	February 20, 1968				
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
male	white		March 13, 1890		77 YRS				
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Md.	U. S.				Baltimore		Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USIA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Catonsville		SPRING GROVE STATE HOSP.		Laborer		Country			
13a. USIA. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.				Balto.		YES <input type="checkbox"/> NO <input type="checkbox"/>		1117 Sargent Street	
14. FATHER'S NAME, First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
William E. Brewer			Mary Graves						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
Army 1917		?		Records: SPRING GROVE STATE HOSPITAL					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction, acute, DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Dis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) Arteriosclerosis, Generalized, Senile APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min. 6 yrs. 6 yrs.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pulmonary Emphysema, Mild.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (X) (this hospital) attended the deceased from Aug. 28, 1963, to Feb. 20, 1968, that (X) (we) last saw the deceased alive on Feb. 20, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Anthony J. Young, M.D.						22c. DATE SIGNED 2-20-68			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		2/24/68		New-Cathedral Cem.		Baltimore Md.			
24. FUNERAL DIRECTOR John J. Cowan & Son Inc.				ADDRESS 901 Hollins St. Baltimore, Md.		25a. REC'D BY REGISTRAR DATE FEB 23 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print) JAMES J. BROOKHART						2a. DATE OF DEATH 2 Month 8 Day 68 Year		2b. HOUR 7:30 PM	
3 SEX M		4. RACE W		5. DATE OF BIRTH 6/4/10		6 AGE (In years last birthday) 57 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTO.			
10. CITY OR TOWN OF DEATH WOODLAWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5924 MONTGOMERY ST.		12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) PLASTER		12b. KIND OF BUSINESS OR INDUSTRY BLDG.			
13a. USUAL RESIDENCE (Where deceased lived, if admission) STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN WOODLAWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 5924 MONTGOMERY ST.	
14. FATHER'S NAME First Middle Last GEORGE BROOKHART				15. MOTHER'S MA-DEEN NAME First Middle Last MARY LINDENBERGER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO 217-206406		17. INFORMANT Address DOROTHY BROOKHART					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary thrombosis 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery disease with myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) 5 yrs.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH none	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1963 , 19 Feb 8 , 19 68 ; that (I) (we) last saw the deceased alive on Feb 4 , 19 68 ; and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John A. Nesbitt Jr.		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 2-10-68			
22d. PHYSICIAN'S NAME (Type) JOHN A. NESBITT, JR.		22e. ADDRESS 108 Frederick Rd. Baltimore Md 21228							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 2/12/68		23c. NAME OF CEMETERY OR CREMATORY WOODLAWN		23d. LOCATION (City or Town) (County) (State) BALTO. CO. Md.			
24. FUNERAL DIRECTOR E.S. MACNAB		ADDRESS 301 FREDERICK RD		25a. REC'D BY REGISTRAR DATE FEB 13 1968		25b. REGISTRAR'S SIGNATURE [Signature]			

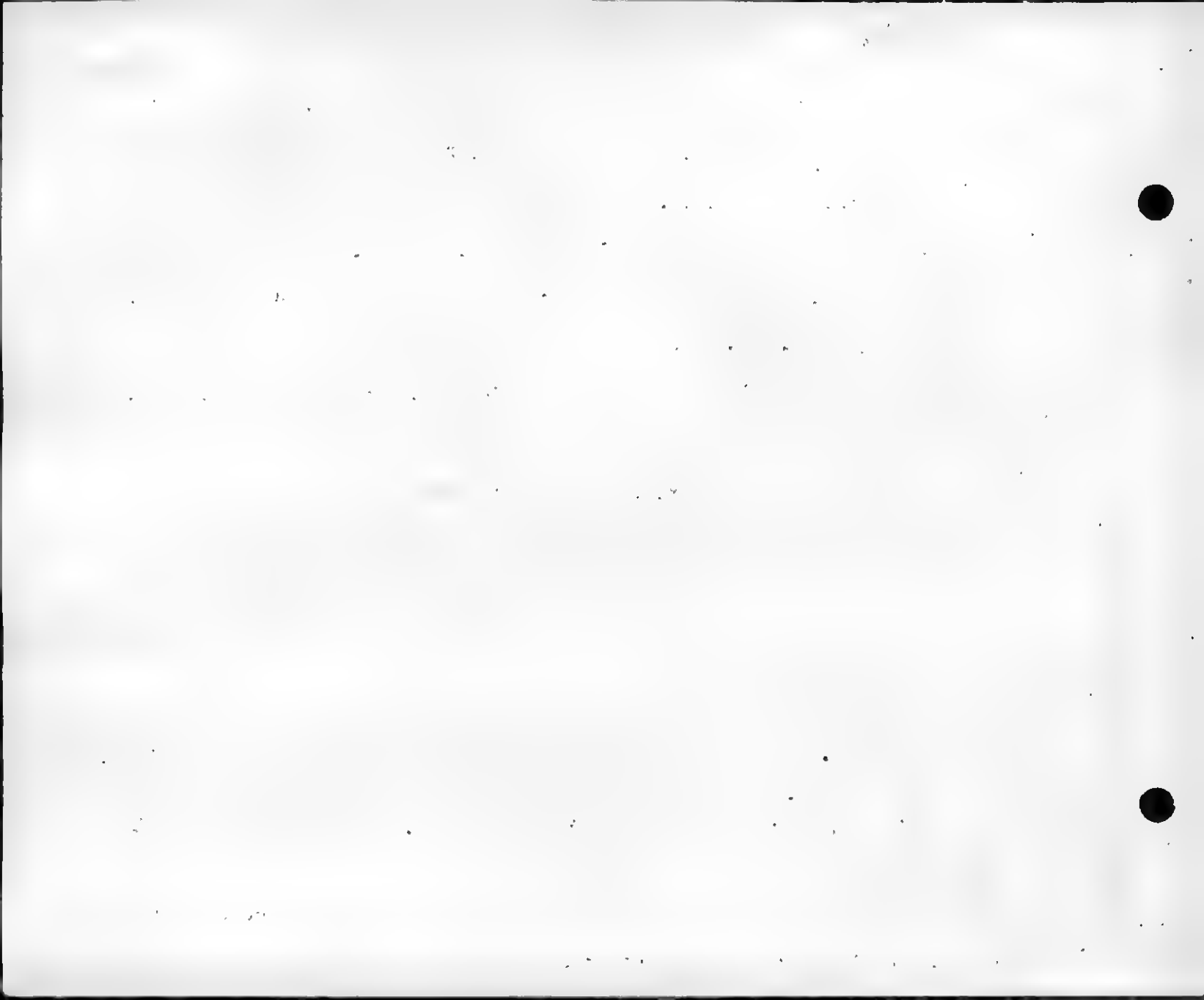


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) Alberta Gibbons Brown		Last		2a. DATE OF DEATH Feb. Month 4 Day 1968		2b. HOUR M	
3 SEX F		4 RACE Cauc.		5. DATE OF BIRTH Oct. 27, 1898		6 AGE (In years birthday) 69 YRS.	
7a. BIRTHPLACE (State or foreign country) Baltimore		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH Baltimore	
10. CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 602 Squires Rd.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 602 Squires Rd. 21204		14. FATHER'S NAME First Middle Last Robert Lee Gibbons		15. MOTHER'S MAIDEN NAME First Middle Last Demereah Blades			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT Ethel B. Norris, 602 Squires Rd. 21204		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, bilateral DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral thrombosis, multiple DUE TO, OR AS A CONSEQUENCE OF (c) 3 years						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) none							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from January , 19 63 , to Jan. 31 , 19 68 , that (I) (we) last saw the deceased alive on Jan. 31 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Ronald O. Wood, MD		22c. DATE SIGNED 2/5/68		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 2-7-68		23c. NAME OF CEMETERY OR CREMATORY Loudon		23d. LOCATION (City or Town) (County) (State) Baltimore, Md, Baltimore	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE FEB 7 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



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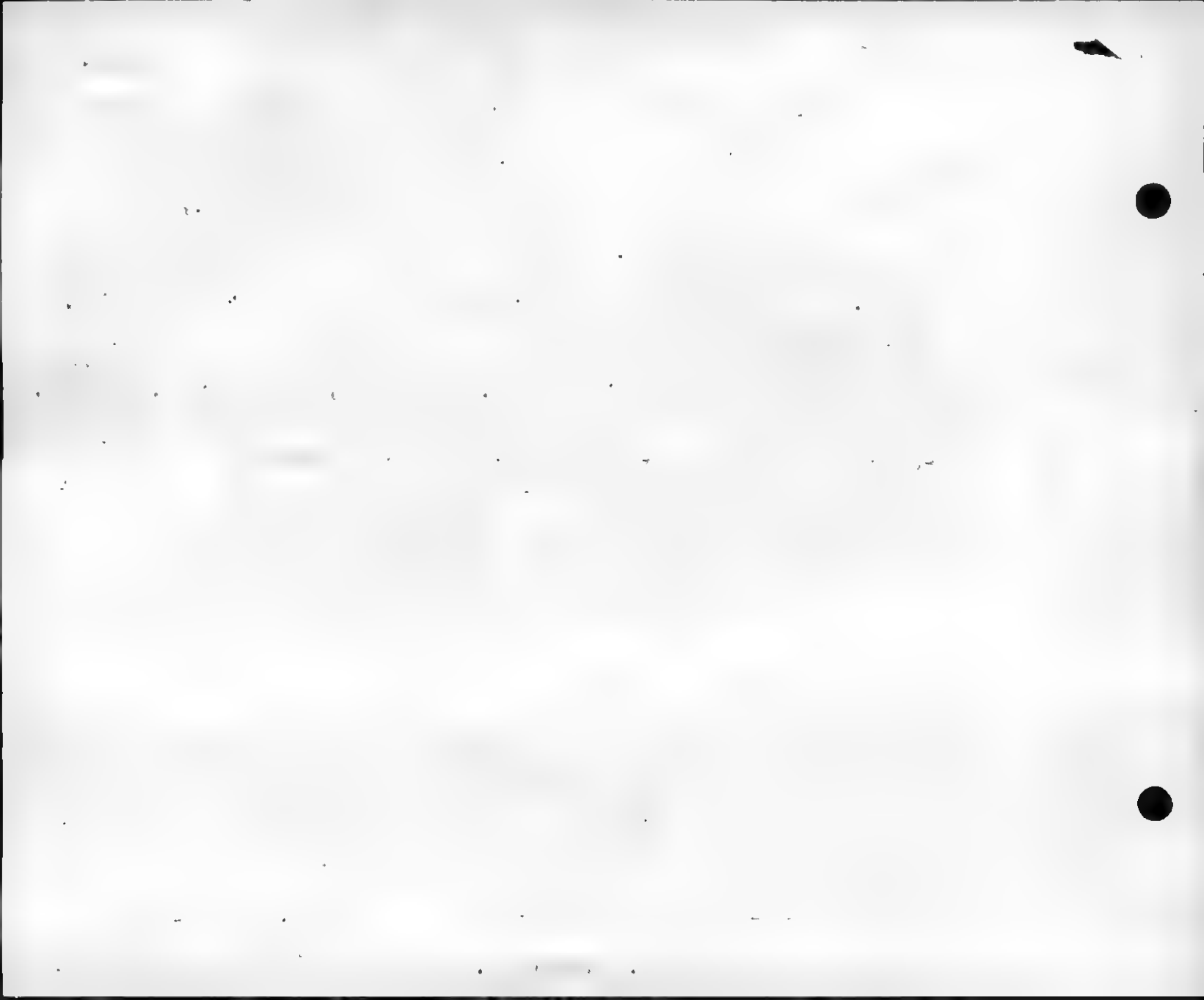
VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
ANGELINE		Czaja	BRZECZKO	February 12, 1968		6:05PM		
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years lost birthday)		7 YRS. MONTHS DAYS	
Female	White		October 7, 1891		76			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Poland	USA				Baltimore Co.,		Md.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
		1629 Manor Road		Housewife		Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Md.		--		Baltimore				
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		13e. STREET AND NUMBER				
Benedict CZAJA		Madeline CZAJA		1100 South Ellwood Ave.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT		Address		
No		212 18 2594		Mrs. Anna Leiben, 1629 Manor Rd. Balto Md.		21222		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								
PART I. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>								
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Influenza</u>								
DUE TO, OR AS A CONSEQUENCE OF (c) <u>2 weeks</u>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from Feb 6 19 68, to Feb 12 19 68, that (I) (we) last saw the deceased alive on Feb 12 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Stephen C. Mackowiak				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-13-68		
22d. PHYSICIAN'S NAME (Type) STEPHEN C. MACKOWIAK				22e. ADDRESS 6714 HOLABIRDAU 21222				
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE 2-16-68		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus		23d. LOCATION (City or Town) (County) (State) Balto. Maryland 21222		
24. FUNERAL DIRECTOR Marie Fialkowski & Son 1000 S. Kenwood Ave.				25a. DEC'D BY REGISTRAR FEB 19 1968		25b. REGISTRAR'S SIGNATURE		

Marie Fialkowski & Son 1000 S. Kenwood Ave.

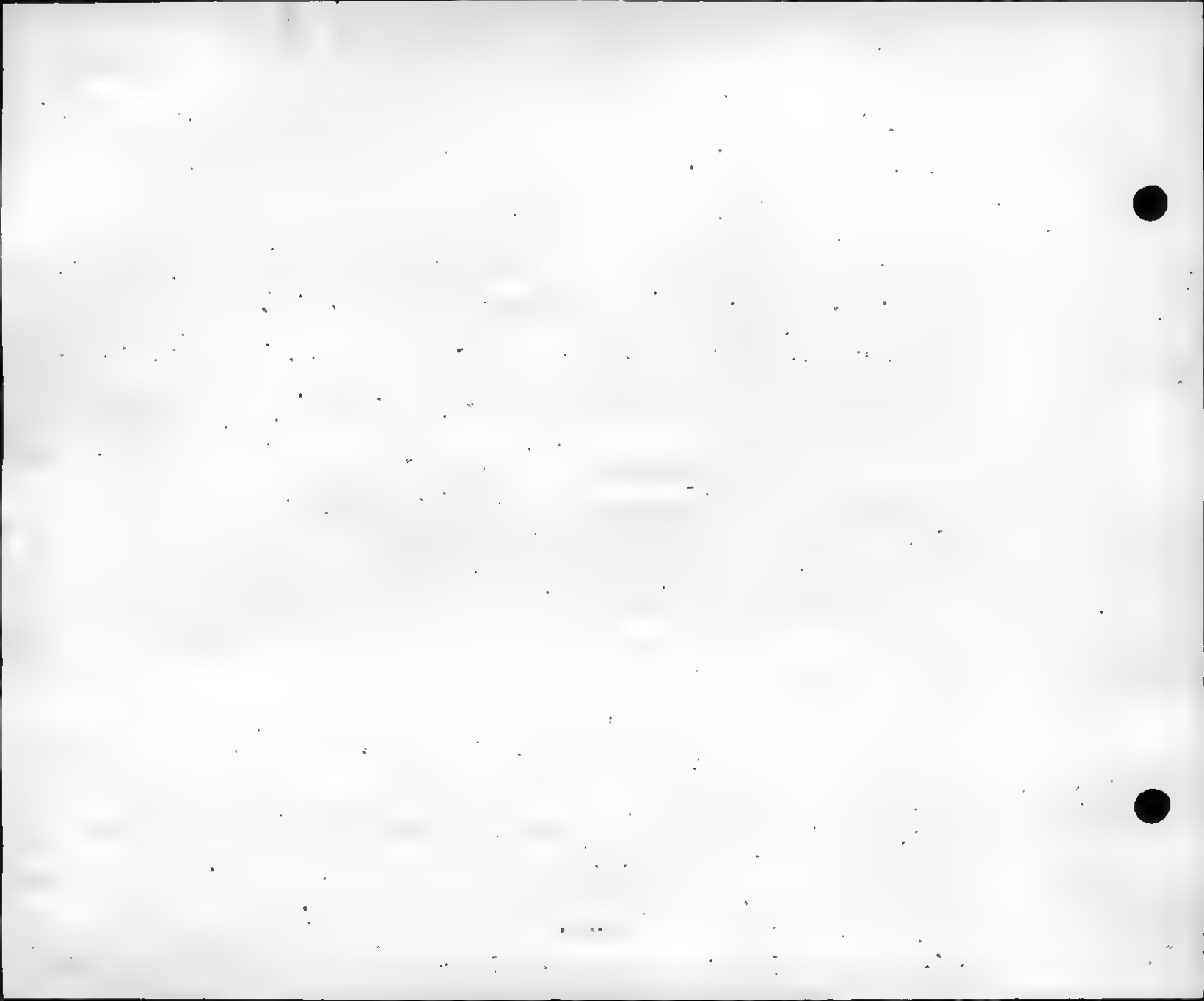
FEB 19 1968



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<div> <div>1- film 2-2-1-52</div> <div>2-2-1-52</div> <div>3-2-1-52</div> </div> <div> <div>1</div> <div>2</div> <div>3</div> </div> <div> <div>1</div> <div>2</div> <div>3</div> </div>												<div> <div>1- film 2-2-1-52</div> <div>2-2-1-52</div> <div>3-2-1-52</div> </div> <div> <div>1</div> <div>2</div> <div>3</div> </div> <div> <div>1</div> <div>2</div> <div>3</div> </div>											
1 DECEASED-NAME (Type or print) <u>Nellie B. Buckingham</u>						2a. DATE OF DEATH <u>2</u> Month <u>10</u> Day <u>10</u> Year <u>68</u>						2b. HOUR <u>4:05 PM</u>											
3 SEX <u>Female</u>		4. RACE <u>White</u>		5 DATE OF BIRTH <u>8/83</u>		6 AGE (In years lost birthday) <u>84</u> YRS.		IF UNDER 1 YEAR MONTHS <u>84</u> DAYS <u>84</u>		IF UNDER 24 HRS HOURS <u>84</u> MIN <u>84</u>													
7a BIRTHPLACE (State or foreign country) <u>md.</u>		7b CIT ZEN OF WHAT COUNTRY? <u>USA</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Baltimore</u>																	
10 CITY OR TOWN OF DEATH <u>USA Catonsville</u>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Shangri-la Nursing Home</u>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Housewife</u>		12b KIND OF BUSINESS OR INDUSTRY																	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>md</u>		13b COUNTY <u>Cecil</u>		13c CITY OR TOWN <u>Westminster</u>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <u>16 Webster St.</u>															
14. FATHER'S NAME First <u>Joseph</u> Middle <u>Brown</u> Last <u>Brown</u>				15. MOTHER'S MAIDEN NAME First <u>Rebecca</u> Middle <u>Arrington</u> Last <u>Arrington</u>				Address															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b SOCIAL SECURITY NO <u>214-32-1460</u>		17 INFORMANT <u>Hosp. Chart</u>																			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Pneumonia</u>												<u>3 days</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Fracture of Humerus</u>																							
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Urinary Tract Infection</u>																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. <u>19</u> Month <u>10</u> Day <u>10</u> Year <u>1968</u>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
2 d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/5</u> , 19 <u>68</u> , to <u>2/10</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2/10</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b SIGNATURE <u>David E. Zick</u>		22c. DATE SIGNED <u>2/10/68</u>		22d. ADDRESS <u>4444 Lane, Ellicott City, Md.</u>																			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE <u>2-13-68</u>		23c NAME OF CEMETERY OR CREMATORY <u>Ebenezer Church</u>		23d. LOCATION (City or Town) (County) (State) <u>Winfield - Carroll - Md.</u>																	
24 FUNERAL DIRECTOR <u>Harry W. Haight</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>FEB 15 1968</u>																	

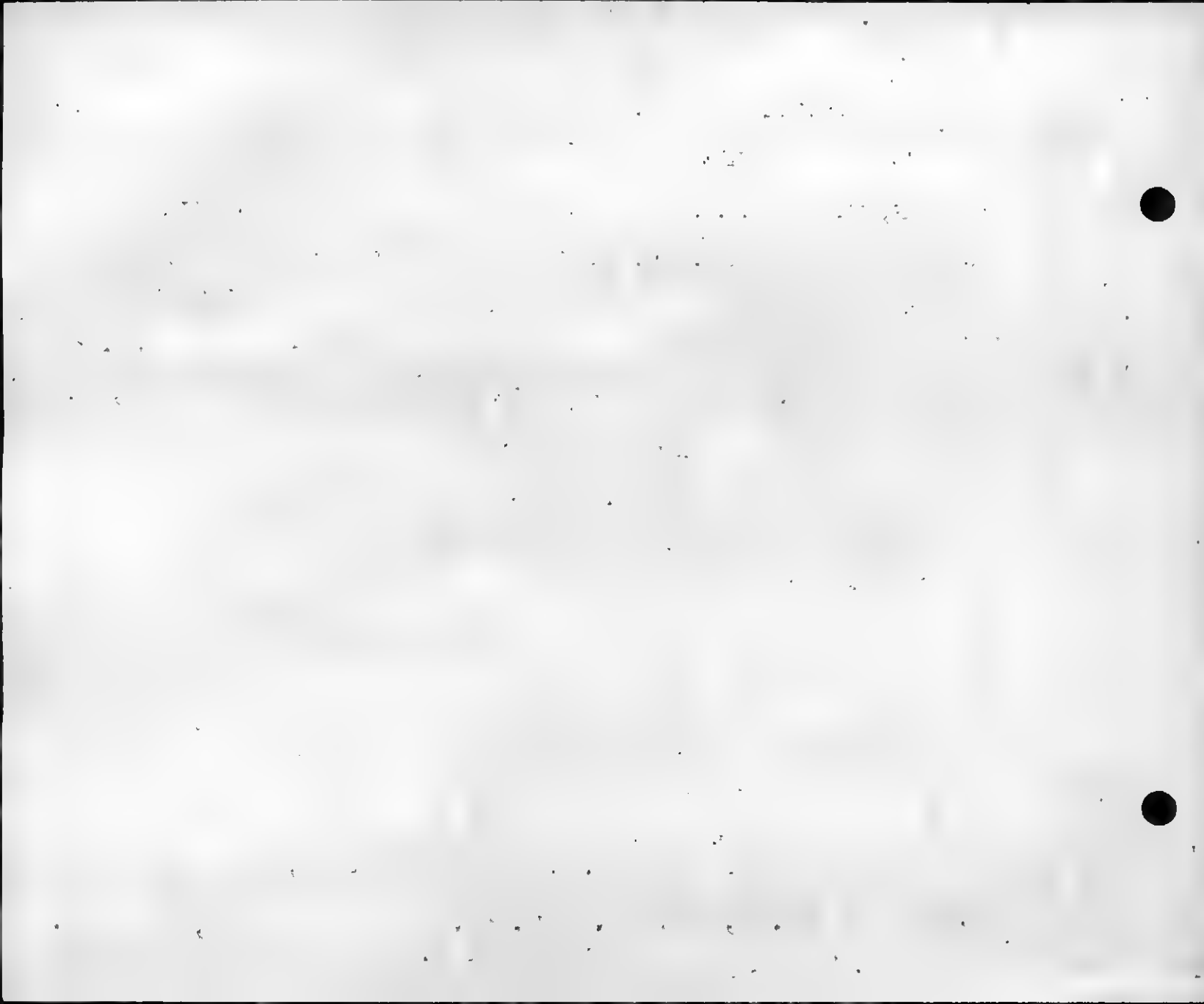


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH														
1. DECEASED-NAME (Type or print)			First HERBERT		Middle C.		Last BURK		2a. DATE OF DEATH Month 2 Day 25 Year 68		2b. HOUR 9:20A			
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 1/3/07			6. AGE (in years last birthday) 61 YRS.		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0		8. IF UNDER 24 HRS HOURS 0 MIN 0	
7a. BIRTHPLACE (State or foreign country) BALTIMORE, MD.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE COUNTY, Md					
10. CITY OR TOWN OF DEATH FORT HOWARD			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. ADM. HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) SILVERSMITH			12b. KIND OF BUSINESS OR INDUSTRY JEWELER					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND			13b. COUNTY BALTIMORE			13c. CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2140 WILKENS AVENUE			
14. FATHER'S NAME First JOHN Middle BURK Last BURK			15. MOTHER'S MAIDEN NAME First FLORENCE Middle TAYLOR Last TAYLOR											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES			16b. SOCIAL SECURITY NO 215 01 75 68			17. INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-37 ASPERATION PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF (c) 2-3-2-2 CEREBRAL ARTERIOSCLEROSIS												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) EPILEPSY DUE TO CEREBRAL INFARCTION														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (b) (this hospital) attended the deceased from 11/3/67 , 19 67 , to 2/25/68 , 19 68 , that (b) (we) last saw the deceased alive on 2/25/68 , 19 68 , and that in (b) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (did) (did not) view the body after death.														
22b. SIGNATURE John D. Talbert, M.D. DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>												22c. DATE SIGNED 2/26/68		
22d. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.												22e. ADDRESS VAH FORT HOWARD, MARYLAND		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE Feb. 29, 1968			23c. NAME OF CEMETERY OR CREMATORY Balto. Nat'l. Cem.			23d. LOCATION (City or Town) (County) (State) Baltimore, Md.					
24. FUNERAL DIRECTOR McCully ADDRESS MC CULLY FUNERAL HOME 25a. REC'D BY REGISTRAR FEB 27 1968 25b. REGISTRAR'S SIGNATURE John D. Talbert														



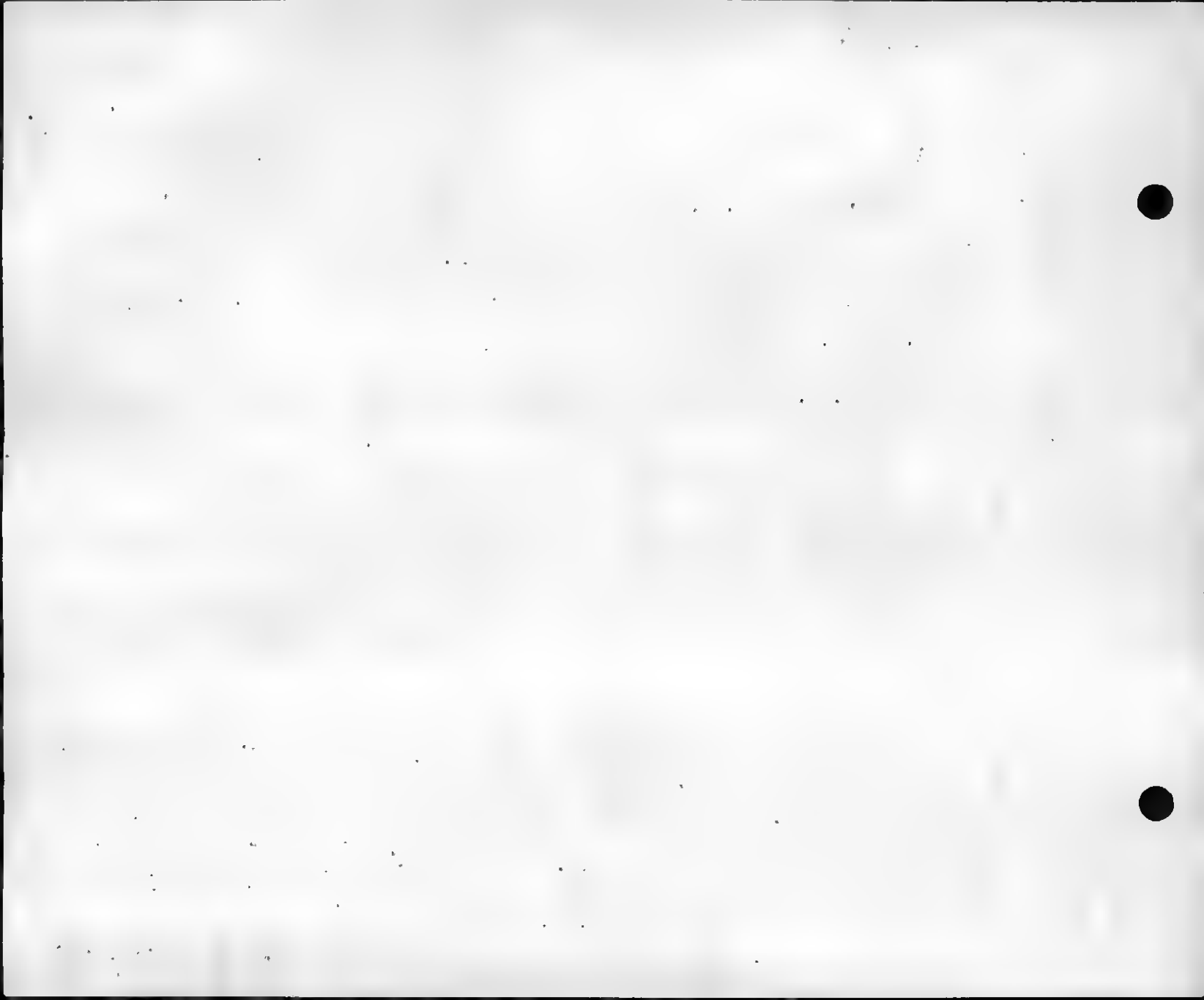
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First		Middle		Last		20. DATE OF DEATH		
Samuel							Butler		Month Day Year		
February 13, 1968									2b. HOUR 5:00 a.m.		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)		
male			Negro			Jan. 8, 1897			71 YRS		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Georgia			U. S.						Baltimore Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)						12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired.)		
Catonsville			SPRING GROVE STATE HOSP.						laborer		
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Md.						Balto.			3320 Remley Avenue		
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME					
First Middle Last						First Middle Last					
Osten Butler						Sarah Baker					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)						16b. SOCIAL SECURITY NO			17. INFORMANT		
yes						W. W. I			Records: SPRING GROVE STATE HOSPITAL		
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <i>Pneumonia</i>											
DUE TO, OR AS A CONSEQUENCE OF											
(b) <i>Due to pneumonia</i>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <i>Due to pneumonia</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
			HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC)				21f. LOCATION				
Where <input type="checkbox"/> Not while <input type="checkbox"/> at work at work							Street or R.F.D. No. City or Town County State				
22a. I certify that (X) (this hospital) attended the deceased from April 29, 1965, to April 14, 1968, that (I) (we) last saw the deceased alive on April 13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.											
22b. SIGNATURE									22c. DATE SIGNED		
Sherwood E. Wilson, M.D.									1/14/68		
22d. PHYSICIAN'S NAME (Type)									22e. ADDRESS		
									SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21227		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			Feb 20-1968		Baltimore National			Baltimore City			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Robert E. Williams						FEB 16 1968			Charles Jones		

MEDICAL CERTIFICATION



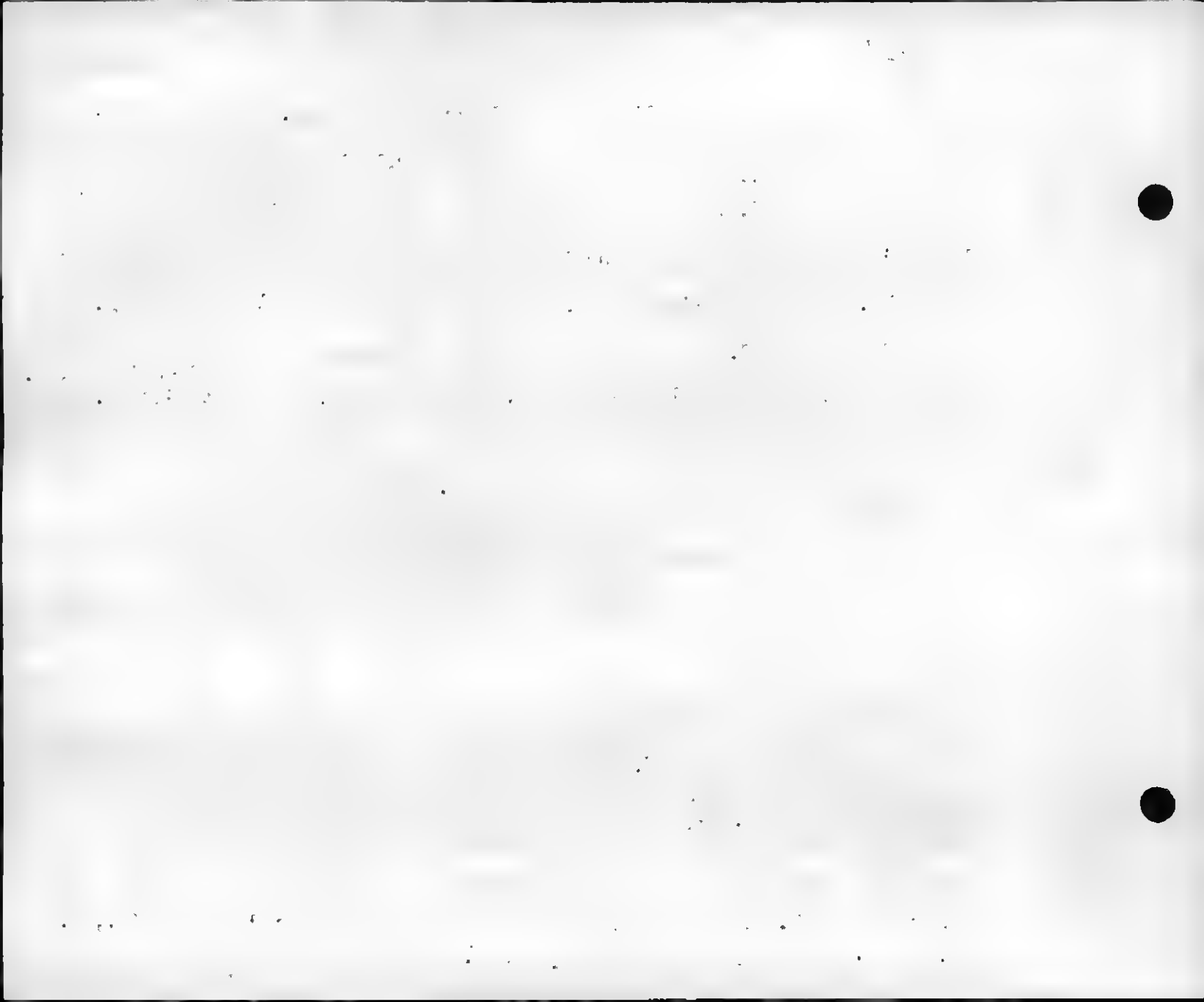
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

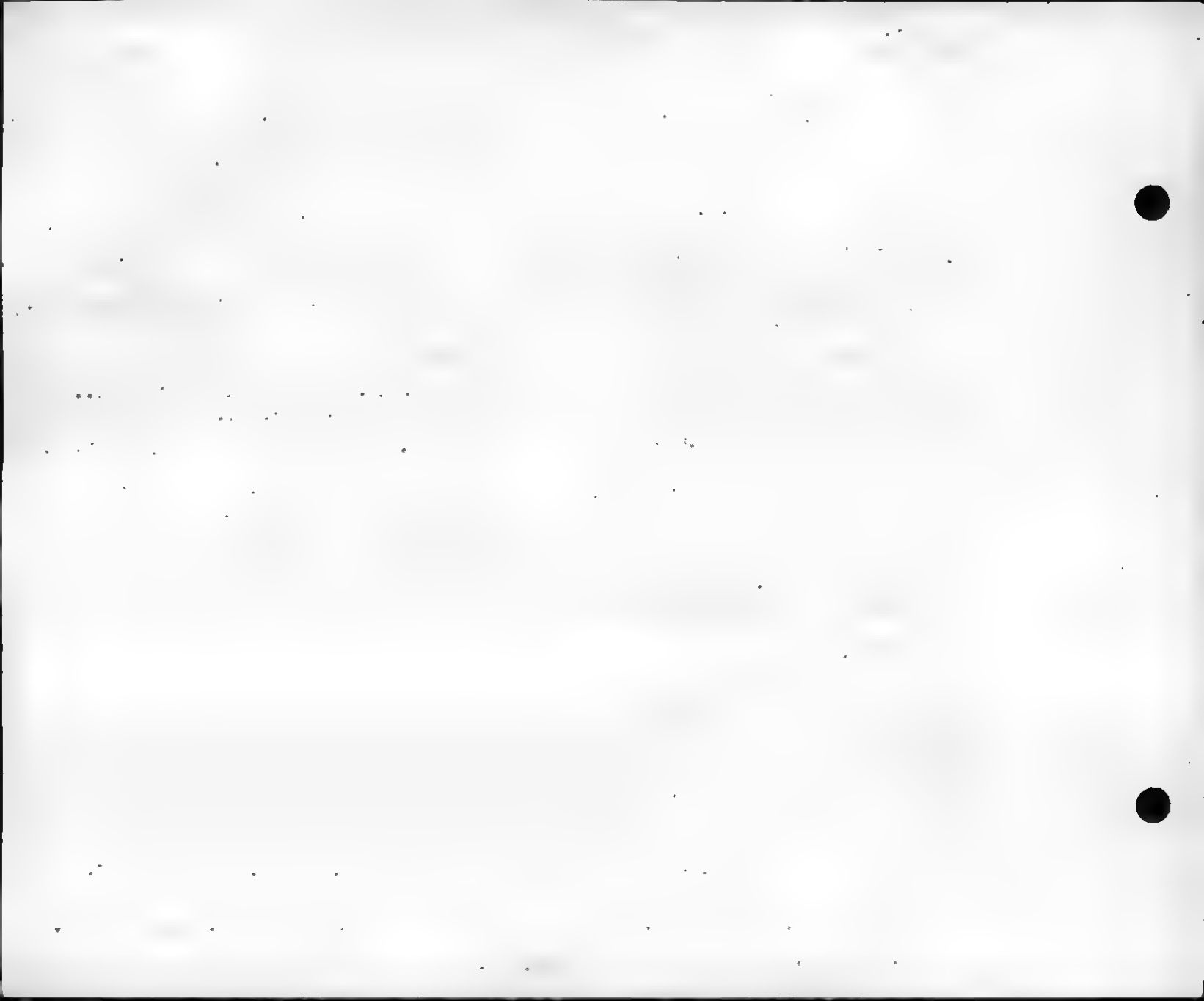
1 DECEASED NAME (Type or print) Merman Clinton Caples			2a DATE OF DEATH Month Feb. Day 9 Year 1968			2b HOUR M	
3 SEX Male		4 RACE White		5. DATE OF BIRTH June 10, 1889		6. AGE (In years lost birthday) 78 YRS	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md	
10 CITY OR TOWN OF DEATH Jatonsville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Jatons Nursing Home		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Care taker		12b. KIND OF BUSINESS OR INDUSTRY Druid Ridge	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Id.		13b COUNTY Baltimore		13c CITY OR TOWN Pikesville		13d INS OF CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME First Middle Last Charles J. Caples		15. MOTHER'S MAIDEN NAME First Middle Last Katherine Shipley					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO		16b SOCIAL SECURITY NO 213-12-0835		17 INFORMANT Mr. Herman Caples, 715 Milford Hill Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4367 IMMEDIATE CAUSE (a) C. V. A DUE TO, OR AS A CONSEQUENCE OF (b) Hemiplegia DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State			
22a I certify that (I) (this hospital) attended the deceased from 1-2- , 19 66 , to 2-9- , 19 68 , that (I) (we) last saw the deceased alive on 2-9- , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Enov Valle Cervero						22c DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE Feb. 12, 1968		23c NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION (City or Town) (County) (State) Pikesville Baltio., Md.	
24 FUNERAL DIRECTOR Frank H. Newell, Pikesville, Md.				25a. REC'D BY REGISTRAR DATE FEB 15 1968		25b REGISTRAR'S SIGNATURE Pikesville	



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) First Middle Last Francis A. Cavey						2a. DATE OF DEATH Month Day Year Feb. 9 1968			2b. HOUR A M			
3 SEX Male		4. RACE White		5. DATE OF BIRTH June 23, 1898			6. AGE (In years last birthday) 69 YRS		7. UNDER 1 YEAR MONTHS DAYS		7. UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County Md						
10. CITY OR TOWN OF DEATH Catonsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Summit Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Proprietor			12b. KIND OF BUSINESS OR INDUSTRY Tavern			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Howard		13c. CITY OR TOWN Glenelg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rt. 144 & Folly Quarter Rd.			
14. FATHER'S NAME First Middle Last Dennis Cavey				15. MOTHER'S MAIDEN NAME First Middle Last Theresa								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 213 28 3300		17. INFORMANT Address Sadie Cavey, Rt. 144 & Folly Quarter Rd. Glenelg, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of pharynx & metastasis to neck & into mediastinum DUE TO, OR AS A CONSEQUENCE OF (c) Diabetic Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours 14 Months		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from Jan 1967 , to 8 Feb 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Robert Z. Berry				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 11 Feb. 1968						
22d. PHYSICIAN'S NAME (Type) Robert Z. Berry				22e. ADDRESS Medical Arts. Bldg., Baltimore, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 12, 1968		23c. NAME OF CEMETERY OR CREMATORY St. Johns		23d. LOCATION (City or Town) (County) (State) Ellicott City, Howard Md.						
24. FUNERAL DIRECTOR Harry H. Witzke, 321 Columbia Pike, City, Md.				25a. REC'D BY REGISTRAR DATE 13 1968		25b. REGISTRAR'S SIGNATURE Charles Judge						

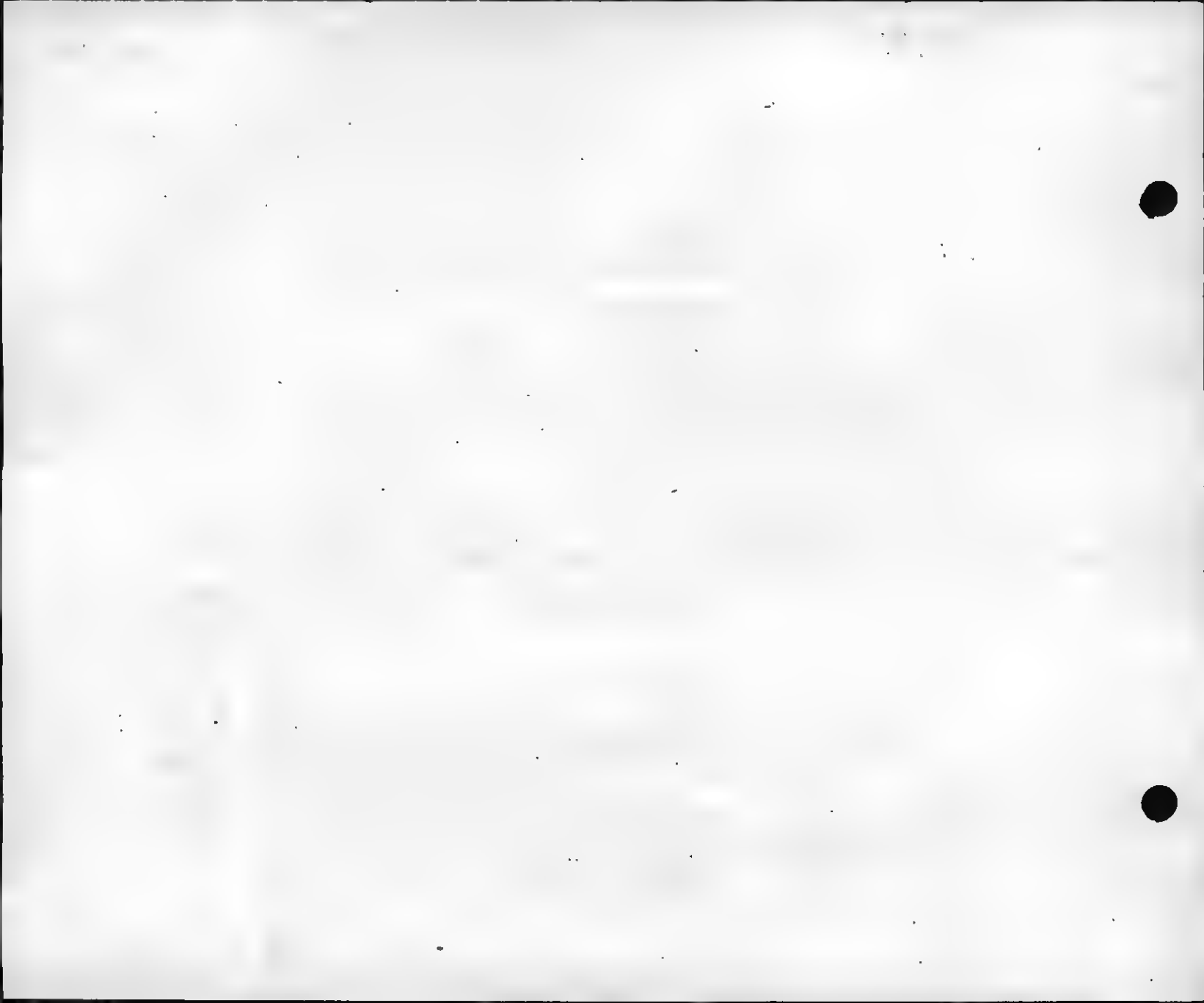


FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF ESTI-DEATH			2b HOUR		
ANNA (CISEWSKI) CESEWSKI						Month Day Year			3:30 PM		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	if UNDER 1 YEAR MONTHS DAYS		if UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD			2d HOUR
F	W	12-25-93	74 YRS					Month Day Year			4:30 PM
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
POLAND			U.S.A.						BALTIMORE Md.		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION (kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
BALTIMORE			121 TREGARONE RD.			HOMEMAKER					
13a USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY OR TOWN?		
MD						BALTO.			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		
FRANK WOJCIECHOWSKI			MARYANNA LISOWSKI			NO					
17a INFORMANT			17b ADDRESS			17c CITY OR TOWN			17d STATE		
WALTER J. CESEWSKI			7614 SPRUCE RD.								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)											
DUE TO, OR AS A CONSEQUENCE OF											
HEMORRHAGE OF BRAIN											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
SKULL FRACTURE											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY?		
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			3:30 AM 3/26 1968			FELL DOWN STAIRS					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No			City or Town County State		
			HOME			121 TREGARONE			TIMONIAN BALTO. Md.		
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			ASSISTANT MEDICAL EXAMINER			22b DATE SIGNED		
WILLIAM A. PILLSBURY									2 26 68		
EXAMINER'S NAME (Type)			ADDRESS			DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town, or county)		
WILLIAM A. PILLSBURY						BALTIMORE					
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
BURIAL			3/1/68			HOLY ROSARY			BALTIMORE MD.		
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE		
RAYMOND L. KACZOROWSKI			2525 FLEET ST			MAR 5 1968					

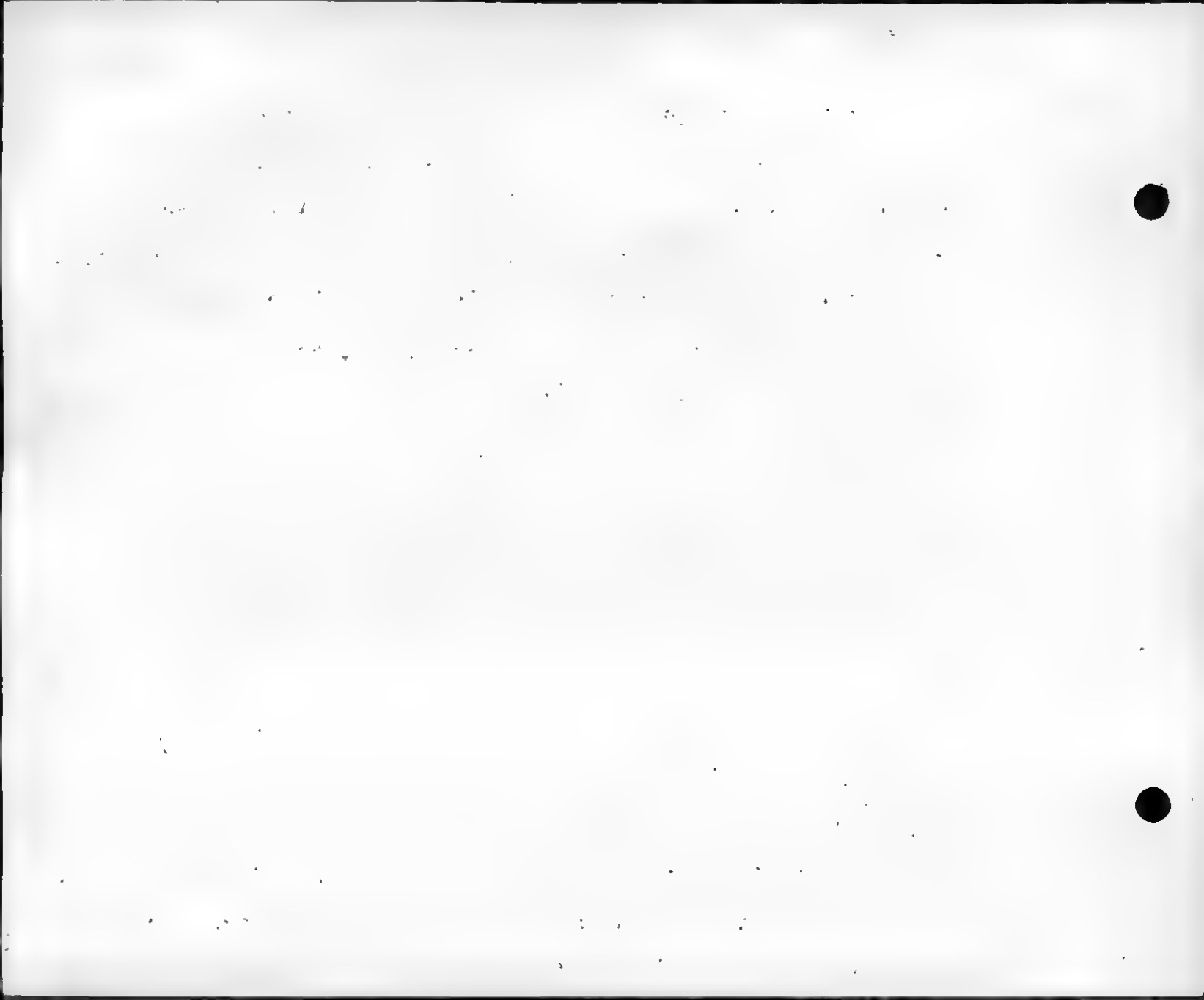


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 must be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15
30M REV. 1-64

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) First Middle Last					2a. DATE OF DEATH Month Day Year			2b. HOUR M		
LEROY J CHESTER					2-26-68					
3 SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		7. UNDER 1 YEAR MONTHS DAYS	
male		white		10-30-1905			62 YRS.		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		USA				Baltimore County Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Parkville			3108 Acton Road			chauffeur		newspaper		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Baltimore		Parkville				3108 Acton Road	
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last					
Charles F. Chester					Frances E. Franz					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
no			212-03-0386		family					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>2/21/68</u> , 19 <u>68</u> , to <u>27 Feb</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>27 Feb</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED		
<u>Howard Goodman</u>			MD					27 Feb 68		
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS							
Howard Goodman			8604 Harford Rd., Balto., Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
burial		2-29-68		Parkwood Cemetery		Baltimore, Maryland				
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
CHARLES F. EVANS & SON			8802 Harford Rd.			DATE FEB 28 1968		<u>Charles Evans</u>		

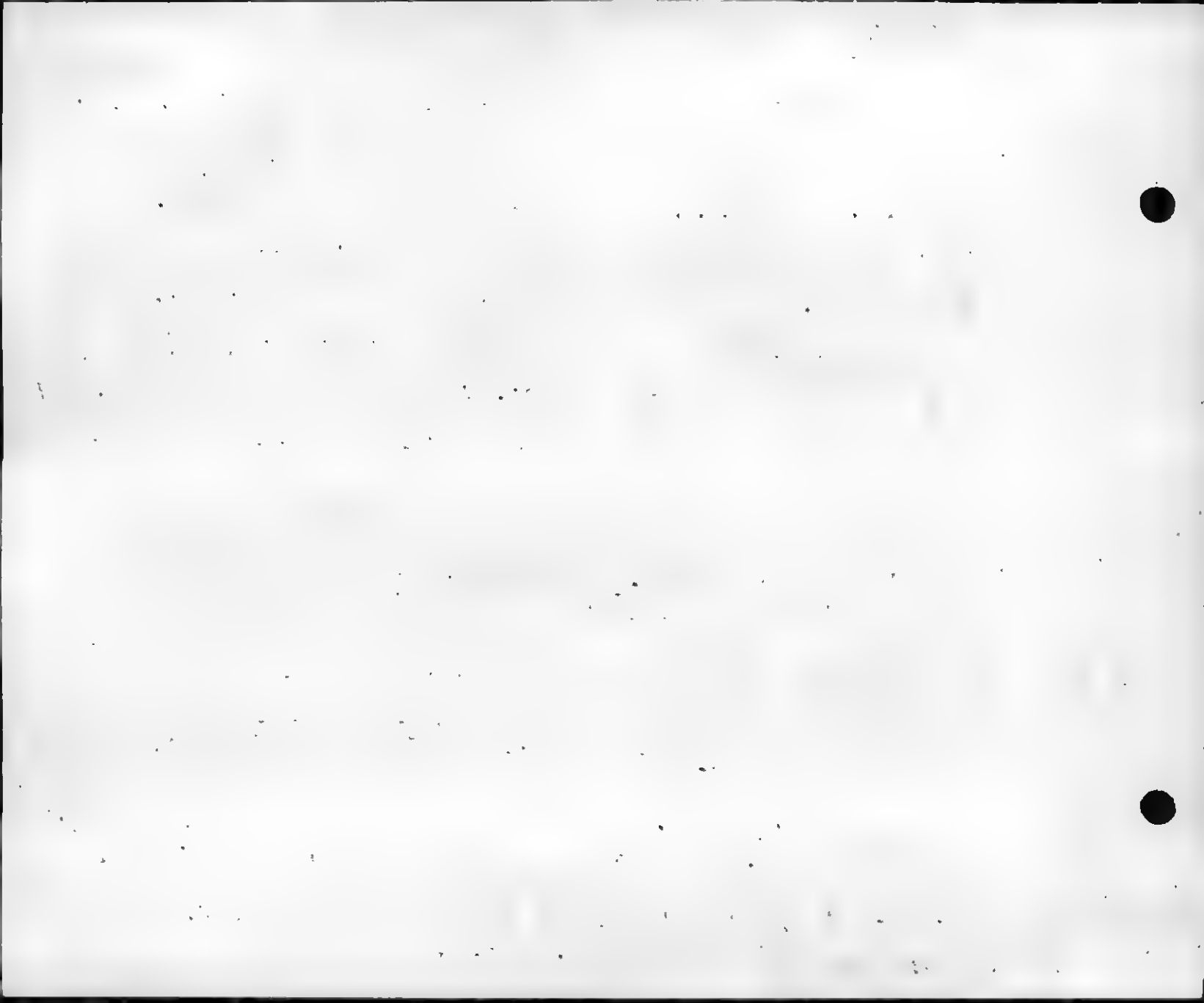


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 21 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD143
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) ROSE E CLOSE			2a. DATE OF DEATH Month 2 Day 11 Year 1968			2b. HOUR 10 AM	
3 SEX F		4. RACE W		5. DATE OF BIRTH Aug 6, 1884		6. AGE (In years last birthday) 83 YRS	
7a. BIRTHPLACE (State or foreign country) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto. Md	
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Summitt Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY At Home	
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland 5009 Elmer Ave.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First George Airey Middle Last		15. MOTHER'S MAIDEN NAME First Catherine Vienmyer Middle Last		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Elizabeth Glass, 5631 Oregon Ave. 21227					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia L. lung. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 weeks
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Hypertrophic cardiomyopathy; A.S.C.D.							
19a. DATE OF OPERATION Feb 13, 1968		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ASCD		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory) Office building, etc.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Feb 13, 1968 to Feb 11, 1968 , that (I) (we) last saw the deceased alive on Feb 8, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Earl Pass		22c. DATE SIGNED 2-11-68		22d. PHYSICIAN'S NAME (Type) EARL PASS			
22e. ADDRESS 400, W. Johns Ave		22f. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/14/1968		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR B. Kenneth		24b. ADDRESS 4611 Park Heights Av. Balto. Md.		25a. REC'D BY REGISTRAR DATE FEB 13 1968		25b. REGISTRAR'S SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02133

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD COUNTY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONS VILLE</u>				c. LENGTH OF STAY IN b. <u>1 year 6 months</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State Hospital</u>				d. STREET ADDRESS <u>Norrisville Road</u>			
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>MAY</u> Last <u>COFIELD</u>				4. DATE OF DEATH Month <u>2</u> Day <u>22</u> Year <u>1968</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-22-98</u>		9. AGE (In years last birthday) <u>69</u> yrs	10. UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		13. BIRTHPLACE (County & State, or foreign country) <u>NEW JERSEY</u>		14. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. FATHER'S NAME <u>GARRETT TICE</u>				16. MOTHER'S MAIDEN NAME <u>Aberella Slocum</u>			
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		18. SOCIAL SECURITY NO. <u>220-14-4827</u>		19. INFORMANT <u>Thomas P. Cofield</u> Address <u>Spring Grove State Hosp Baltimore Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Massive heart infarction</u> <u>+104</u> DUE TO (b) <u>Heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (c) <u>Generalized Arteriosclerosis</u>							INTERVA. BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome due to Cerebral Arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-19</u> , 19 <u>66</u> , to <u>2-22</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2-22</u> 19 <u>68</u> , and that death occurred at <u>8:35 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Narciso Aristigueta</u>				22b. DATE SIGNED <u>2/22/1968</u>		22c. PHYSICIAN'S NAME (Type) <u>NARCISO ARISTIGUETA</u>	
22d. ADDRESS <u>SPRING GROVE STATE HOSP.</u>				22e. MED. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/24/1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ayres Chaple</u>		23d. LOCATION (City or Town) (County) (State) <u>Shawsville, Harford, Md.</u>	
24. FUNERAL DIRECTOR <u>Charles E. Kurtz Jarrettsville, Md.</u>				25a. REC'D BY REGISTRAR <u>FEB 26 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 1 and 2 director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY

VR A15ME (5)
10M REV 1/68

72145

1 DECEASED NAME (Type or Print) <u>Risdon Hayes Coleman</u>		2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <u>2</u> Day <u>18</u> Year <u>1968</u>		2b HOUR <u>4:30</u> MIN <u>PM</u>	
3 SEX <u>M</u>	4 RACE <u>W</u>	5 DATE OF BIRTH <u>May 2, 1893</u>	6 AGE, in years (month/day) <u>68</u> YRS	7a BIRTHPLACE (State or foreign country) <u>Mo.</u>	7b CITIZEN OF WHAT COUNTRY? <u>USA</u>
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <u>Baltimore</u>		10 CITY OR TOWN OF DEATH <u>Woodlawn</u>	
11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>5311 Lewellen</u>		12a USLA OCCUPATION (Kind of work done during most of working life, even if retired) <u>Office</u>		12b KIND OF BUSINESS OR INDUSTRY <u>B&O RR</u>	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>MD.</u>		13b COUNTY <u>Balto</u>		13c CITY OR TOWN <u>Woodlawn</u>	
13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <u>5311 Lewellen Ave</u>		14 FATHER'S NAME First <u>Harry G.</u> Middle <u>Coleman</u> Last <u></u>	
15 MOTHER'S MAIDEN NAME First <u>Sarah L.</u> Middle <u>Bauscher</u> Last <u></u>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16b SOCIAL SECURITY NO. <u>705.05.2473</u>	
17 INFORMANT <u>Irma R. Coleman</u>		18 ADDRESS <u>Same as 13e</u>		19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio-Vascular Disease</u>		DUE TO, OR AS A CONSEQUENCE OF (b) <u></u>		DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u></u>		19a. DATE OF OPERATION <u></u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <u></u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u></u>		21b. TIME OF INJURY Month, Day Year <u>19</u>	
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <u></u>		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u></u>	
21f. LOCATION Street or R.F.D. No <u></u> City or Town <u></u> County <u></u> State <u></u>		22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. DATE SIGN <u>2/15/68</u>	
22c. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22d. ADDRESS (Street, city, town, or county) <u>Balto, MD 21227</u>		22e. SIGNATURE OF EXAMINER <u>James N. Frederick</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2/21/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>	
23d. LOCATION (City or Town) (County) (State) <u>Baltimore Balto. Md.</u>		24. FUNERAL DIRECTOR <u>J. I. Stansbury</u>		25a. REC'D BY REGISTRAR <u>FEB 21 1968</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>		25c. ADDRESS <u>6411 Windsor Mill Rd.</u>		25d. DATE <u>FEB 21 1968</u>	



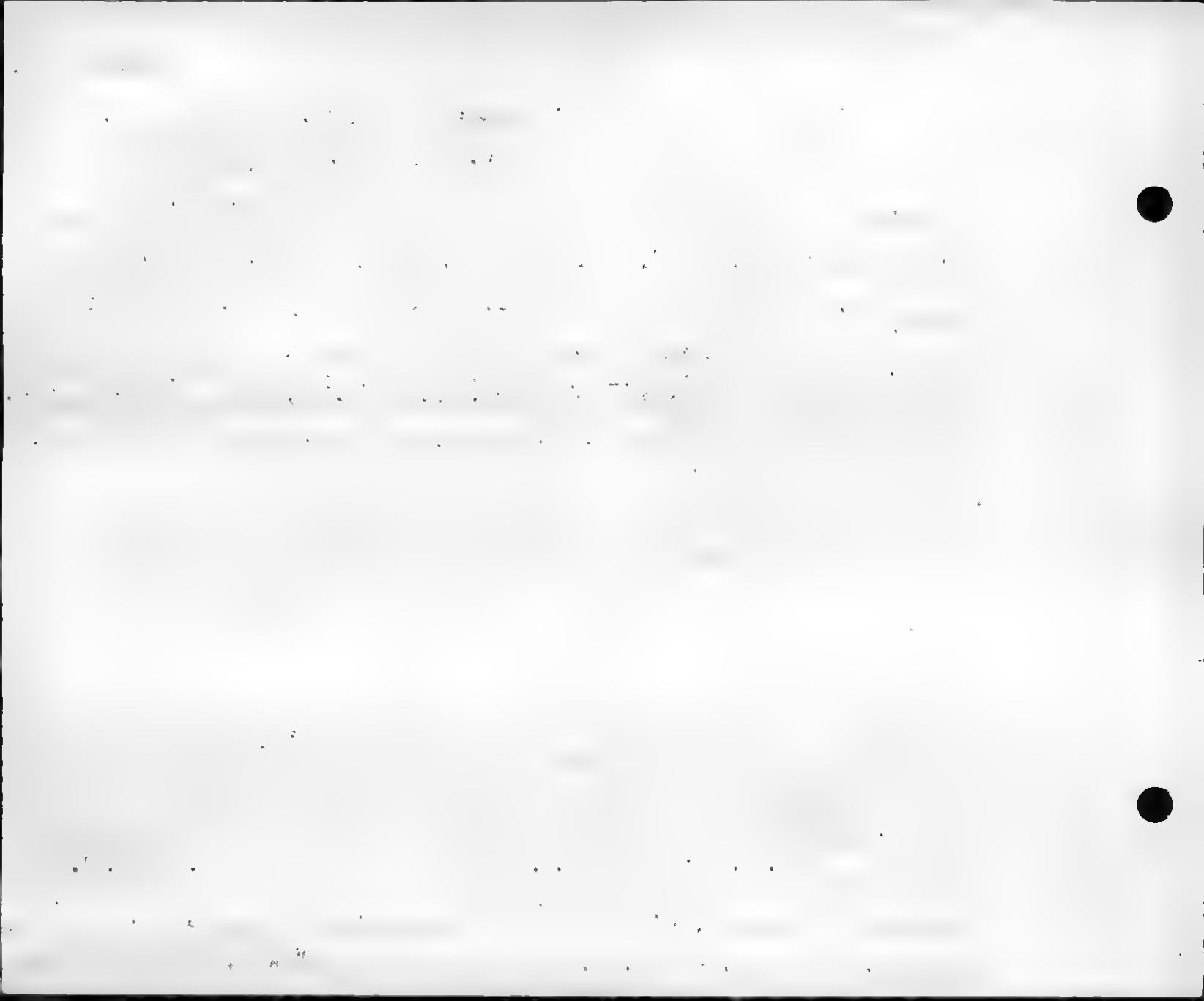
TO VITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MD146
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last <i>Peter Constantinides</i>			2a. DATE OF DEATH Month Day Year <i>Feb. 18, 1968</i>		2b. HOUR Min <i>7:40 P.M.</i>
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>Nov. 12, 1883</i>		6. AGE (In years last birthday) <i>84</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>Turkey</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Baltimore</i> Md.		
10. CITY OR TOWN OF DEATH <i>Lutherville</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>108 W. Seminary Ave.</i>	12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) <i>Retired Owner Restaurant</i>	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Balto.</i>	13c. CITY OR TOWN <i>Balto.</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>3047 Northern Parkway</i>	
14. FATHER'S NAME First Middle Last <i>Gus Kosta Constantinides</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Despina Anash</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <i>No</i>		16b. SOCIAL SECURITY NO. <i>219-32-1473</i>	17. INFORMANT Address <i>Mrs. Mary Pillas, 108 W. Seminary Ave.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Carcinoma of the lungs, metastatic</i> <i>162.1</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROX. MATH. INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>165</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19 <i>68</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State <i>Harford 13 52 Feb 18, 1968</i>		
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov 13, 1968</i> to <i>Feb 18, 1968</i> , that (I) (we) last saw the deceased alive on <i>Feb 18, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>E. J. Alessi</i> M.D.		22c. DATE SIGNED <i>2/20/68</i>		22d. PHYSICIAN'S NAME (Type) <i>E. J. Alessi</i> M.D.	
22e. ADDRESS <i>6217 Harford Rd. Balto. Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>2/22/68</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Greek Orthodox Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Md.</i>	
24. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc. Balto. Md. 21214</i>		25a. REC'D BY REGISTRAR DATE <i>FEB 20 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

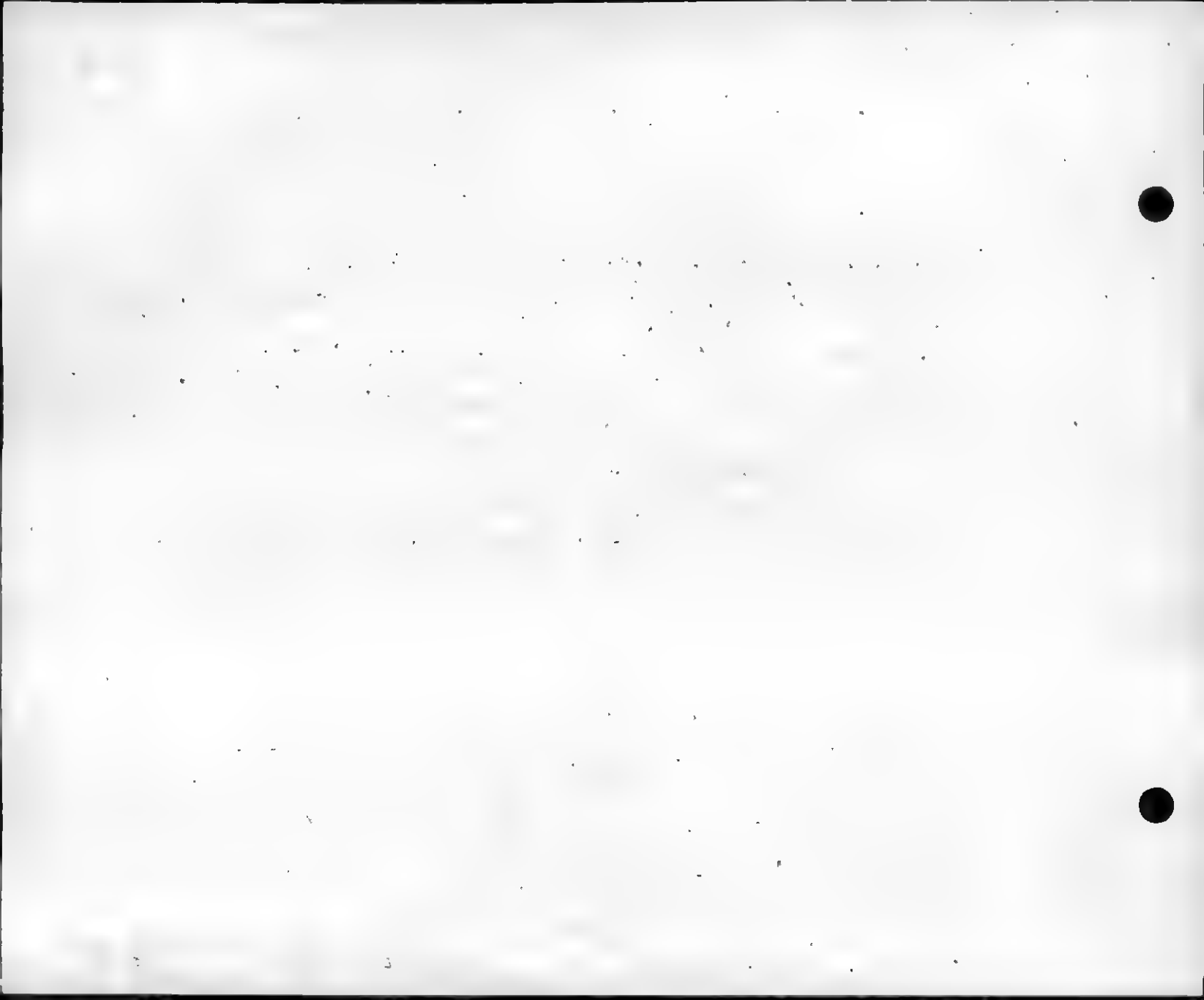


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
304A REV 1/68

<div style="text-align: center;"> <p>22147</p> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</p> <p>CERTIFICATE OF DEATH</p> <p>22136</p> </div>												
1 DECEASED-NAME (Type or print) Elizabeth				First Coupling Middle Last				2a DATE OF DEATH Month February Day 23 Year 1968			2b HOUR 11:50 MIN	
3 SEX Female		4 RACE Colored		5 DATE OF BIRTH 4-26-1905			6 AGE (in years last birthday) 62 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Baltimore		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md						
10 CITY OR TOWN OF DEATH Towson, Maryland		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker			12b KIND OF BUSINESS OR INDUSTRY				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland				13b COUNTY Baltimore		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 7405 Beech Avenue		
14 FATHER'S NAME First Anderson Middle Deasley Last				15 MOTHER'S MAIDEN NAME First Elizabeth Middle Wheeler Last								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)				16b SOCIAL SECURITY NO		17 INFORMANT Wanda Shawell, 922 Denzies Rd. 121220 Address						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROX MATH INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Uremia												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												
(b) Diabetes mellitus.												
(c) Kimmelstiel Wilson disease.												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
MEDICAL CERTIFICATION												
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (X) (this hospital) attended the deceased from February 23, 1968 , to 2-23- , 19 68 , that (X) (we) last saw the deceased alive on 2-23- , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Jaime M. Singzon, M.D. DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>								22c. DATE SIGNED February 23, 1968				
22d. PHYSICIAN'S NAME (Type) Jaime M. Singzon, M.D.								22e. ADDRESS 7620 York Road, Towson, Maryland 21204				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE Feb 27, 1968		23c NAME OF CEMETERY OR CREMATORY Chase Street Cem. - Chase St		23d LOCATION (City or Town) (County) (State)						
24. FUNERAL DIRECTOR Joseph T. Elickson ADDRESS						25a REC'D BY REGISTRAR FEB 27 1968 DATE		25b REGISTRAR'S SIGNATURE John Judge				

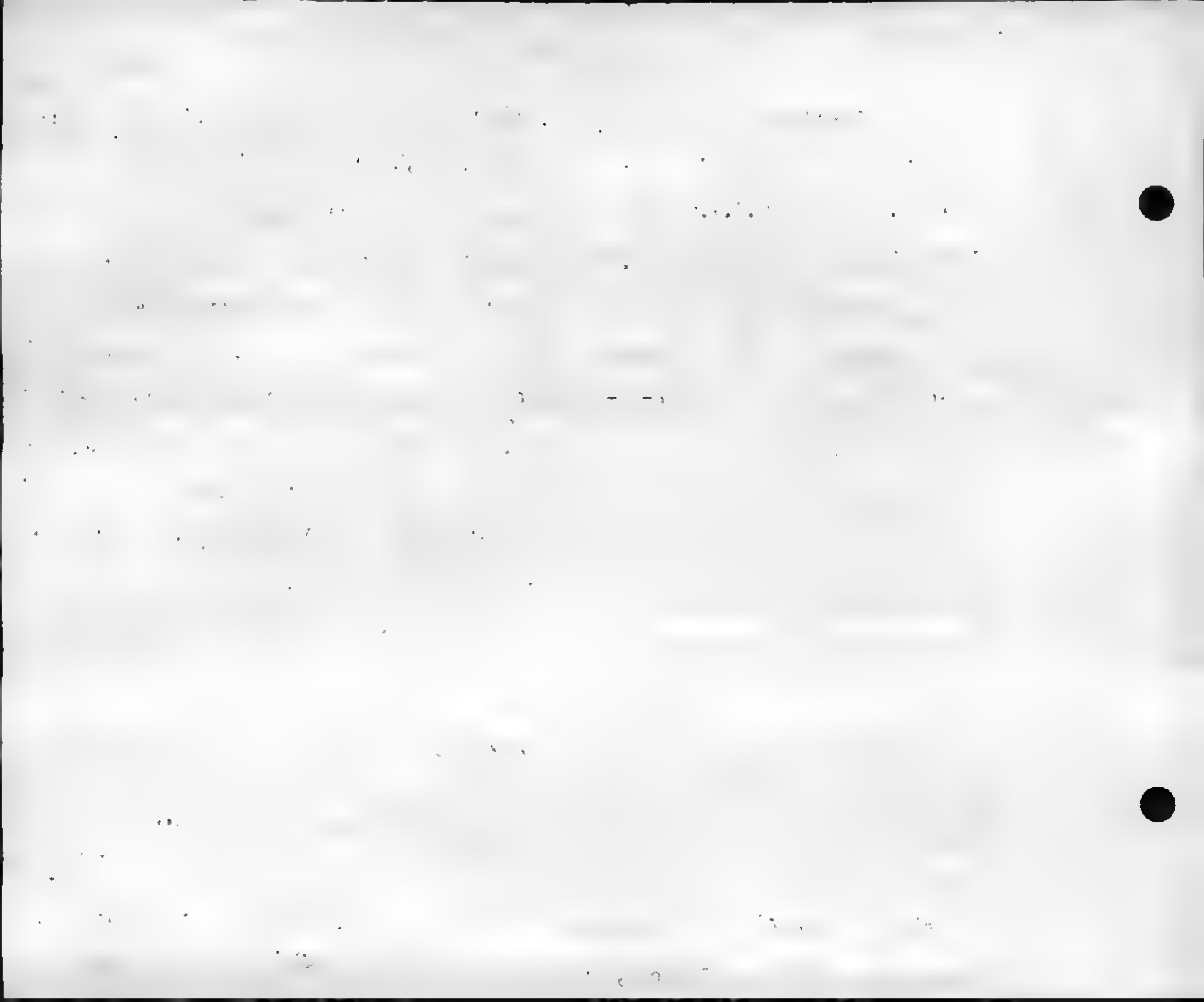


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove catalog pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
304 REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH													
1 DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH			2b. HOUR		
Katherine		H		Cover		Month 2 Day 22 Year 68			5:15 PM				
3. SEX		4 RACE		5 DATE OF BIRTH				6 AGE (n years last birthday)		FUNDING YEAR		FUNDING 24 HRS	
FEMALE		White		April 16, 1880				87 YRS		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH							
Penna.		U.S.A.				Baltimore Md							
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY				
Catonsville		Caton Ridge Nursing Home				Housewife							
13a USUA. RES DENCE (Where deceased lived, if institution: Res dence before admission) STATE		13b. COUNTY		13c CITY OR TOWN		13d INS DE CITY LIM 157		13e STREET AND NUMBER					
Maryland				Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3201 Batavia Ave					
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First		Middle	
Charles		M		Corwell				Anna		J		Kane	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO		17. INFORMANT		Address							
No		212-22-4610B		Raymond G Cover		2908 Dunbrin Court		21222					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>Pneumonia</u>													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Dehydration</u>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
4201 Previous myocardial infarction													
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
		HOUR A.M. Month Day Year P.M. 19											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION		Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from August 9, 1967, to August 9, 1967, that (I) (we) last saw the deceased alive on August 9, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED							
22a PHYSICIAN'S NAME (Type)		22b ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)			
Burial		2/26/68		Parkwood		Baltimore		Maryland					
24. FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Leonard J Ruok-Ino		Baltimore, Maryland		DATE FEB 23 1968		J Charles Judge							



MDARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

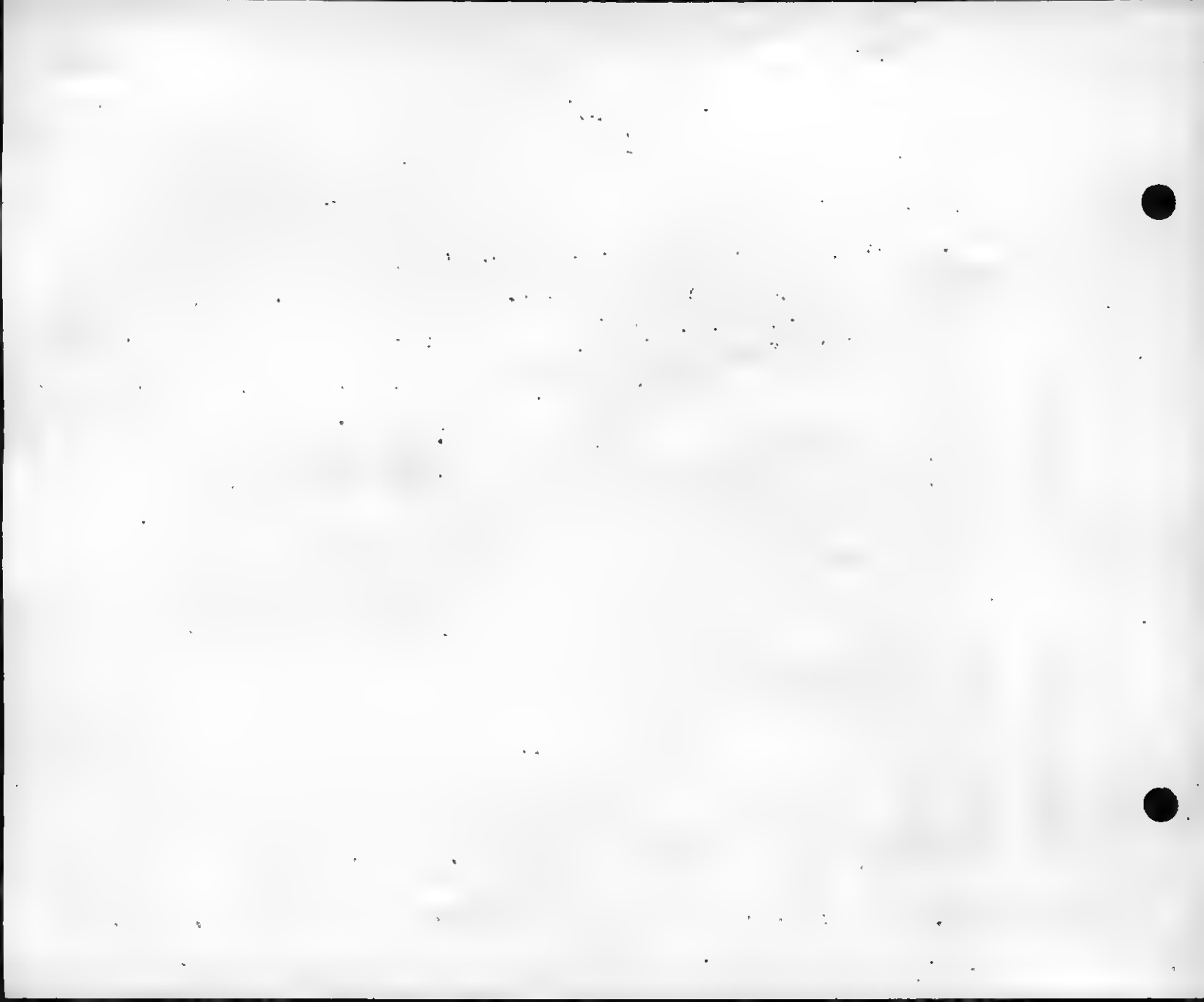
CERTIFICATE OF DEATH

02138

1. DECEASED-NAME (Type or print) COXE First CALLYSTA Middle A ELEN Last			2a. DATE OF DEATH Month 2 Day 25 Year 68		2b. HOUR 11:30 PM
3. SEX Female	4. RACE white	5. DATE OF BIRTH 11/4/15		6. AGE (in years last birthday) 52 YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore County, Md		
10. CITY OR TOWN OF DEATH Mount Wilson	11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp. to give street address) Mt. Wilson St. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUA. RESIDENCE (Where deceased lived, if institution on: Residence before, admission) STATE MARYLAND 13b. COUNTY ST. MARY	13c. CITY OR TOWN LEONARDTOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Box 64		
14. FATHER'S NAME First PAUL Middle WILLIAM Last GREEN		15. MOTHER'S MA DEN NAME First ADA			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO 216-01-8855	17. INFORMANT Address Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) STATUS ASTHMATICUS DUE TO, OR AS A CONSEQUENCE OF BRONCHIAL ASTHMA (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 2-12 , 19 68 , to 2-25 , 19 68 , that (I) (we) last saw the deceased alive on 2-25 , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE W. Newcomer		DEGREE M.D.	ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 2-26-68	
22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.		22e. ADDRESS Mount Wilson, Maryland			
23a. BURIAL, CREMATION, BOWA (Specify) BURIAL	23b. DATE 2-25-1968	23c. NAME OF CEMETERY OR CREMATORY HILLCREST BURIAL PARK	23d. LOCATION (City or Town)	(County)	(State)
24. FUNERAL DIRECTOR Daniel Thomas of Home Thriftway, Md		25a. REC'D BY REGISTRAR DATE FEB 29 1968	25b. REGISTRAR'S SIGNATURE Charles [Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



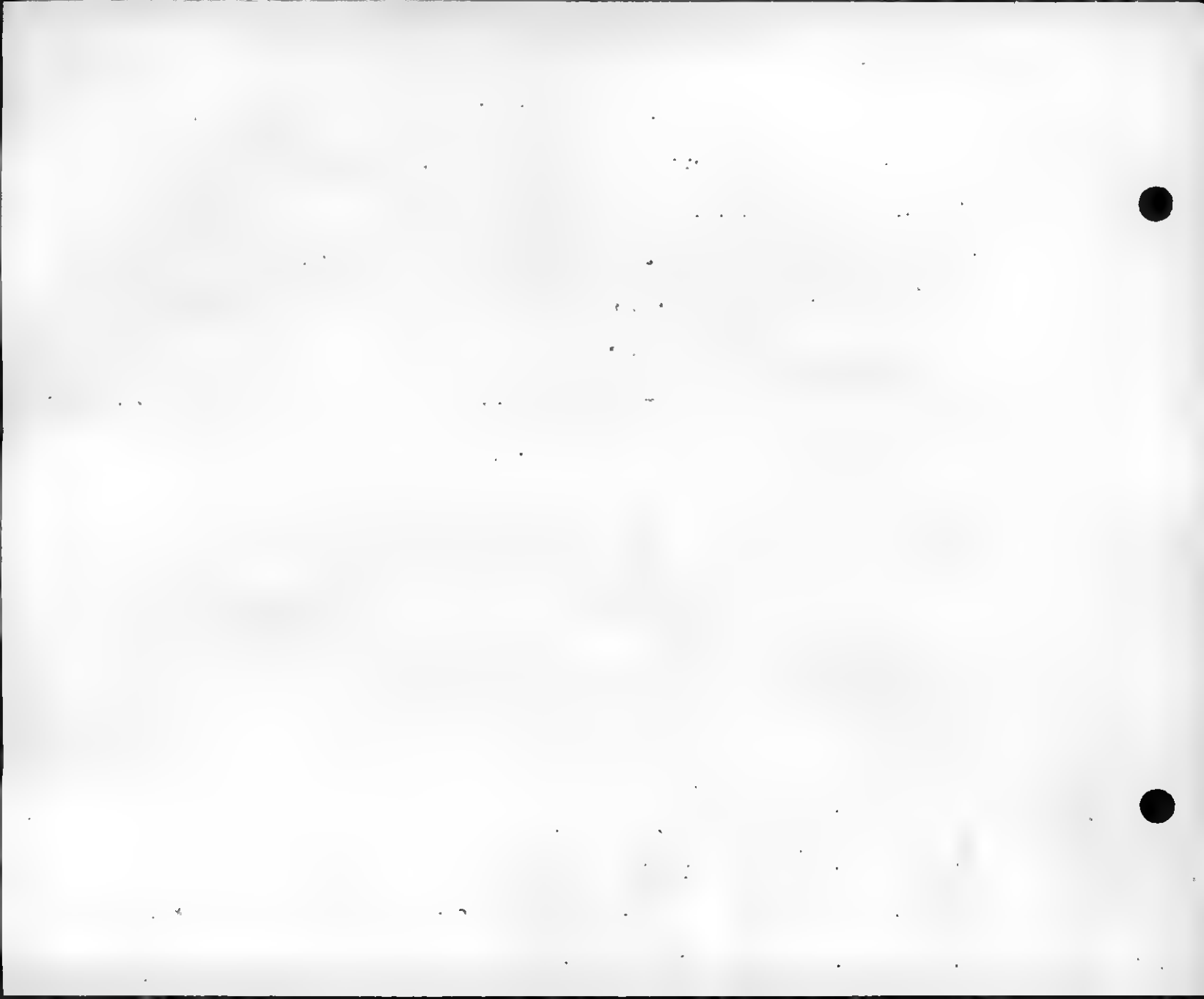
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VR A15 (4)
304A REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) SUE		First E. Middle CRAUMER Last		2a. DATE OF DEATH Month February Day 6 , Year 1968		2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Sept. 24, 1886		6. AGE (In years last birthday) 81 YRS.	
7a. BIRTHPLACE (State or foreign country) Penn.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md	
10. CITY OR TOWN OF DEATH Timonium		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5 Northwood Drive		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Timonium		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 5 Northwood Drive		14. FATHER'S NAME First William Middle Craumer Last		15. MOTHER'S MAIDEN NAME First Alice Middle Hedrick Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 215-56-4454T		17. INFORMANT Mrs. Fannie Tracey		Address 5 Northwood Dr. 21093	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio Vascular Disease 4120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 77							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1-5-1968 , to 2-6-1968 , that (I) (we) last saw the deceased alive on 2-5-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE M. X. Quinn MD DEGREE MD				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 2-7-68	
22d. PHYSICIAN'S NAME (Type) M. KEVIN QUINN MD				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/9/68		23c. NAME OF CEMETERY OR CREMATORY Jessop Methodist Cemetery		23d. LOCATION (City or Town) (County) (State) Cockeysville, Md.	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Rd. 21204				25a. REC'D BY REGISTRAR DATE FEB 13 1968		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

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VR 115 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02151

CERTIFICATE OF DEATH

021411

1 PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Chesapeake Manor Nursing Home</i>		d. STREET ADDRESS <i>Carroll Ave</i>	
3 NAME OF DECEASED (Type or print) First <i>Belle</i> Middle <i>Marlin</i> Last <i>Crockett</i>		4 DATE OF DEATH Month <i>February</i> Day <i>15</i> Year <i>1968</i>	
5 SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 23, 1885</i>
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>	11 BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>John Martin</i>		14. MOTHER'S MAIDEN NAME <i>Matilda McGadden</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i> <i>none</i>		17. INFORMANT <i>Family records</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> <i>4389</i> DUE TO (b) <i>Generalized Cerebral vascular disease</i> DUE TO (c) <i>10 years</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <i>Walter T. Kees</i>		22b. DATE SIGNED <i>15 February 1968</i>	
22c. PHYSICIAN'S NAME (Type) <i>WALTER T. KEES</i>		22d. ADDRESS <i>Cockeysville, Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	23b. DATE THEREOF <i>Feb. 17, 1968</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Towson Park Cemetery</i>	23d. LOCATION (City or town) (County) (State) <i>Baltimore, Md</i>
24. FUNERAL DIRECTOR <i>John W. ...</i>		25a. REC'D BY REGISTRAR DATE <i>FEB 20 1968</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the form PM-3 (Page 5 may be retained for your files).

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print) Donald Norval Crosby, SR.			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 2 Day 18 Year 1968			2b HOUR 3:45 P.M.					
3 SEX M	4 RACE W	5 DATE OF BIRTH AUG. 24, 1917	6 AGE (In years last birthday) 50 YRS	7a BIRTHPLACE (State or foreign country) MARYLAND	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore		2c DATE PRONOUNCED DEAD Month 2 Day 18 Year 1968		2d HOUR 4:00 P.M.
10 CITY OR TOWN OF DEATH Woodlawn			11 NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address) DOGWOOD ROAD			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) CHAUFFEUR		12b KIND OF BUSINESS OR INDUSTRY TRUCKING			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD			13b COUNTY Balto.			13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 8120 Old Philadelphia Rd	
14. FATHER'S NAME First GARDNER Middle CROSBY Last CROSBY			15 MOTHER'S MAIDEN NAME First LILLIAN Middle HARPER Last HARPER								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b SOCIAL SECURITY NO			17 INFORMANT ADDRESS MRS. ETHEL M. CROSBY, SAME AS 13A,B,E					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) multiple Traumatic Injuries									sudden		
DUE TO, OR AS A CONSEQUENCE OF (b) Automobile Accident (TRUCK)											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
1225											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day Year 3:00 P.M. 2 18 68			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Truck overturned on road					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) DOGWOOD ROAD			21f LOCATION Street or R.F.D. No Woodlawn City or Town Baltimore County MD State MD					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
22a. I certify that I took charge of the remains described above, held on			Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE James N. Frederick			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED 2/19/68		
EXAMINER'S NAME (Type) James N. Frederick			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) 1311 FARMER AVE. BALTO MD. 21227					
23a BURIAL CREMATION, REMOVAL (Specify) BURIAL			23b DATE FEB. 20, 1968			23c NAME OF CEMETERY OR CREMATORY SUNNYRIDGE CEMETERY			23d LOCATION (City or Town) (County) (State) CRISFIELD - SOMERSET - MD.		
24 FUNERAL DIRECTOR BRADSHAW & SONS - CRISFIELD, MD.			ADDRESS			25a REC'D BY REGISTRAR FEB 23 1968			25b REGISTRAR'S SIGNATURE Charles Judge		



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BW3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

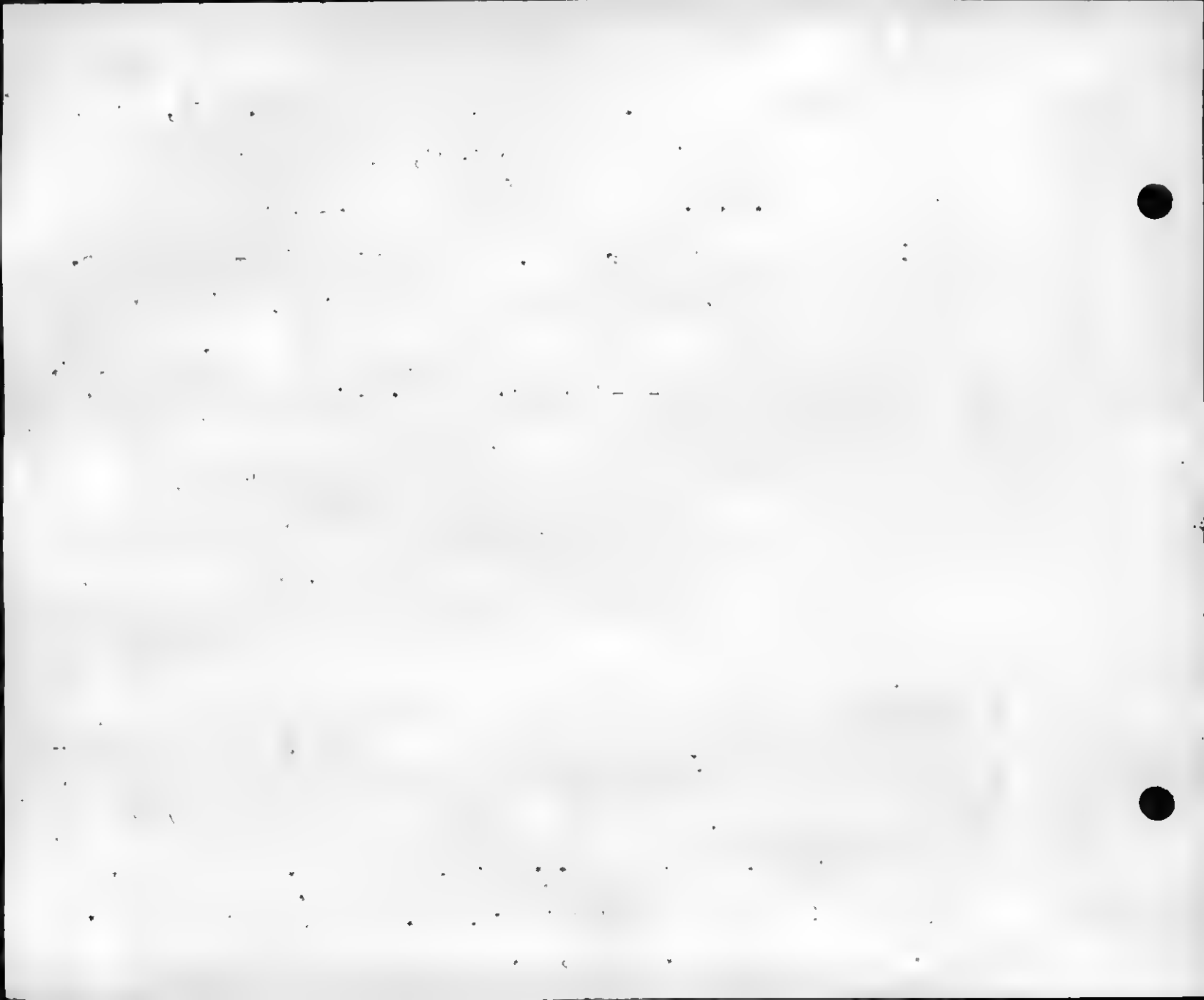
<div> <div>Item 18 film 398</div> <div>2-5-68 153</div> </div> <div> <div>398</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div>												
1 DECEASED NAME (Type or Print) First Middle Last NORMAN ALLEN CROSS						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year 2 14 19 68 10:40			2b. HOJR 6810:40			
3. SEX Male		4 RACE White		5 DATE OF BIRTH Nov. 21, 1966		6 AGE (in years last birthday) MONTHS DAYS HOURS MIN 1 YRS		7. F UNDER 24 HRS 1		2c. DATE PRONOUNCED DEAD Month Day Year February 14 19 68 10:40		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W-DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Balto.			
10 CITY OR TOWN OF DEATH Reisterstown				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) D.O.A. at Dr. McWilliams				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) ---			12b. KIND OF BUSINESS OR INDUSTRY ---	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Md.				13b. COUNTY Balto.		13c. CITY OR TOWN Reisterstown		3d. INSIDE CITY - MTS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 309 Leyton Rd.		
14 FATHER'S NAME First Middle Last Don Allen Cross						15 MOTHER'S MAIDEN NAME First Middle Last Toshiko Taketomi						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b. SOCIAL SECURITY NO. None		17 INFORMANT ADDRESS Don A. Cross 309 Leyton Rd. Reis.Md.						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial pneumonia 484X DUE TO, OR AS A CONSEQUENCE OF: (b) Acute nteritis DUE TO, OR AS A CONSEQUENCE OF: (c) --- CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost 525X												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ---												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Edward F. Wilson, M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED February 14, 1968			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE Feb. 16, 1968		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park			23d. LOCATION (City or Town) (County) (State) Howard County, Maryland			
24 FUNERAL DIRECTOR ADDRESS 4 J Ehlhardt Owings Mills, Md.						25a. REC'D BY REGISTRAR DATE FEB 19 1968		25b. REGISTRAR'S SIGNATURE Charles J. ...				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02154										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH										2143														
1. DECEASED-NAME (Type or print)					First Catherine Middle M. Last Crouse					2a. DATE OF DEATH					2b. HOUR P.									
Feb. 10, 1968					1:40 P.																			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years lost birthday)			7. UNDER 1 YEAR			8. UNDER 24 HRS.									
Female			White			April 17, 1916			51 YRS			MONTHS DAYS HOURS MIN												
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH									
Maryland					U. S. A.										Baltimore Md									
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)					12b. KIND OF BUSINESS OR INDUSTRY									
Dundalk					6745 Roberts Ave.					Reproduction - Baltimore Co.														
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET AND NUMBER				
Maryland					Baltimore					Dundalk					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					6745 Roberts Ave.				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																			
First Raymond Middle Wilby Last					First Anna Middle L. Last Hand																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)					16b. SOCIAL SECURITY NO					17. INFORMANT (Husband)					Address									
No					219-12-8586					Mr. James H. Crouse, 6745 Roberts Ave.					Dundalk, Md.									
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 1 DEATH WAS CAUSED BY:																								
IMMEDIATE CAUSE (a) <i>Generalized Convulsions</i>																								
1541 DUE TO, OR AS A CONSEQUENCE OF																								
(b) <i>Recurrent Adrenocortical Deficiency</i>															1 year.									
DUE TO, OR AS A CONSEQUENCE OF																								
(c) <i>Primary Ad Deficiency</i>															2 years.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																								
<i>Recent Profuse Hemorrhage from Ad. Mass. Perineum</i>																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)														
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					HOUR A.M. Month Day Year P.M. 19																			
2 d. INJURY OCCURRED					21a. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION					Street or R.F.D. No. City or Town County State									
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>																								
22a. I certify that (I) (this hospital) attended the deceased from Jan 1965 to Feb 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																								
22b. SIGNATURE															22c. DATE SIGNED									
<i>M. J. Jaworski M.D.</i>															2/12/68									
22d. PHYSICIAN'S NAME (Type)															22e. ADDRESS									
Melvin J. Jaworski M.D.															2711 Eastern Ave. Baltimore, Md.									
23a. BURIAL CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)									
Burial					2/14/68					Baltimore National Cem.					Baltimore Md.									
24. FUNERAL DIRECTOR															25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
John J. Duda, 7922 Wise Ave. Dundalk, Md.															DATE FEB 14 1968									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

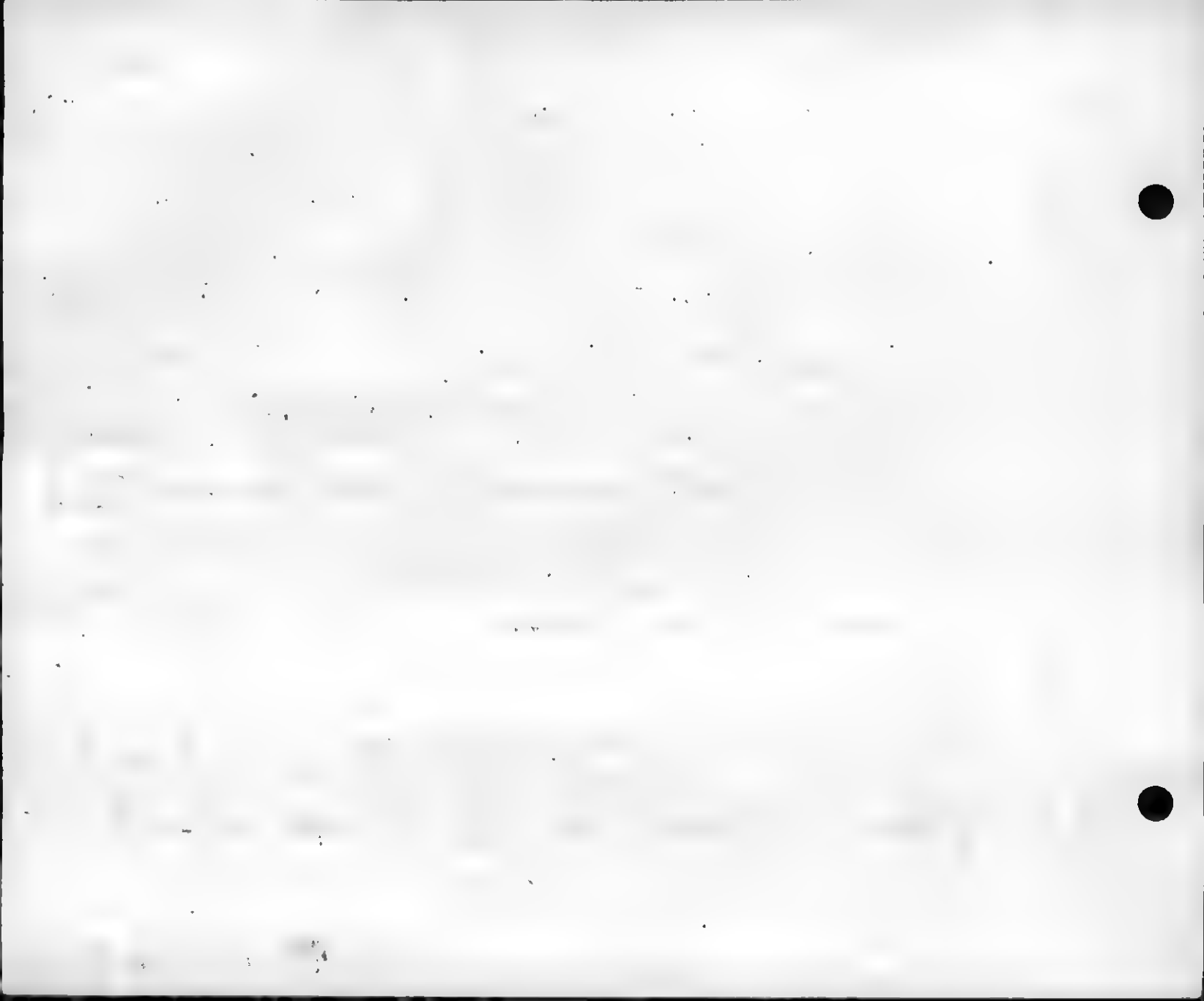
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last John OR GIOVANNI DALLATEZZA			2a. DATE OF DEATH 2 Month 19 Day 68 Year		2b. HOUR 11:40 PM
3 SEX Male	4 RACE White	5. DATE OF BIRTH 11-29-90		6 AGE (In years last birthday) 77 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Italy	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore-RANDALLSTOWN Md		
10. CITY OR TOWN OF DEATH Randallstown Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Baltimore County TILE SECT	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Md.	13b. COUNTY BALTO	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 205 S Ext St. R. 1b. 21202	
14 FATHER'S NAME First Middle Last Anthony DALLATEZZA		15. MOTHER'S MAIDEN NAME First Middle Last GIUSEPPINA GRANAISE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO 131-01-8296	17. INFORMANT Chant MRS. ANGELA DALLATEZZA		
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4127 DUE TO, OR AS A CONSEQUENCE OF (b) GANGRENE OF INTESTINE ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) MESENTERIC THROMBOSES APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days days years					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pneumonia ASPIRATION					
19a. DATE OF OPERATION 2-19-68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED MESENTERIC THROMBOSES		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 2-19-1968, to 2-19-1968, that (I) (we) last saw the deceased alive on 2-19-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d d) (did not) view the body after death.					
22b. SIGNATURE Josue C. Laredo, MD.		DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 2-19-68	
22d. PHYSICIAN'S NAME (Type) Josue C. Laredo		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Feb. 24/68	23c. NAME OF CEMETERY OR CREMATORY LORDON PARK		23d. LOCATION (City or Town) (County) (State) BALTO - Md.	
24. FUNERAL DIRECTOR Frank V. [unclear]		ADDRESS 3125 High St.		25a. REC'D BY REGISTRAR FEB 23 1968 25b. REGISTRAR'S SIGNATURE [unclear]	



02156

1
MAY 1968
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12145

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale		c. LENGTH OF STAY IN 1b 10 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1405 Spring Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF Harold First S. Middle Daniels Last Sr.		4. DATE OF DEATH Feb 23, 1968	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 16, 1913
9. AGE (In years last birthday) 55 yrs		10. IF UNDER 1 YEAR Months 7 Days 7 Hours 1 Min 0	11. IF UNDER 24 HRS Hours 1 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elec. Truck Repair		10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward T. Daniels		14. MOTHER'S MAIDEN NAME LNA. M. Sherwood	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 221-03-3831	
17. INFORMANT Emma F. Daniels		Address 1405 Spring Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO Atherosclerotic Coronary Vessel Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Coronary Artery Disease (c) Chronic Coronary Artery Disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 42.1			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from MAY 1966 to FEB 1968 , that (I) (we) last saw the deceased alive on FEB 20 1968 , and that death occurred at 11:45 PM , from the causes and on the date stated above.			
22a. SIGNATURE John G. Orth, M.D.		22b. DATE SIGNED 2/25/68	
22c. PHYSICIAN'S NAME (Type) John G. Orth, M.D.		22d. ADDRESS 8019 Philadelphia Road 21237	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb 26 1968	
23c. NAME OF CEMETERY OR CREMATORY Catholics of Faith Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Philip Z. Cruch		25a. REC'D BY REGISTRAR FEB 27 1968	
ADDRESS 1211 Chesaco Ave.		25b. REGISTRAR'S SIGNATURE Charles J. Judge	

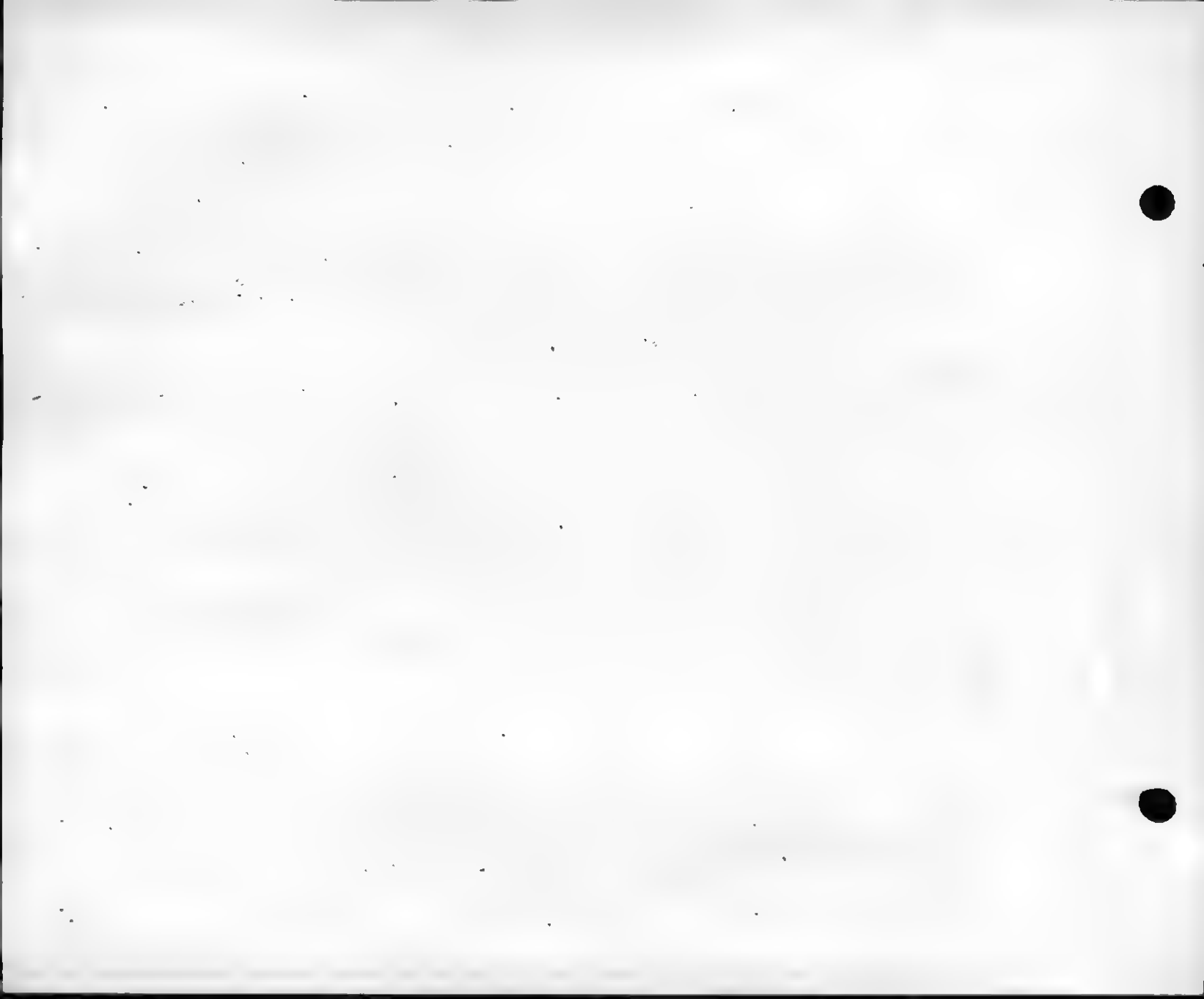


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in (by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 2 and 3) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12157
M
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last LAWRENCE R. DAWLEY		2a. DATE OF DEATH Month Day Year FEB 25 1968		2b. HOUR 5 A. M.	
3. SEX M	4. RACE W	5. DATE OF BIRTH AUG. 11, 1895		6. AGE (In years last birthday) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MD	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE Md		
10. CITY OR TOWN OF DEATH CATONSVILLE		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 6601 RANNOCH DRIVE		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) EDITOR	12b. KIND OF BUSINESS OR INDUSTRY CLOTHING
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.		13b. COUNTY BALTO.	13c. CITY OR TOWN CATONSVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 6601 Rannoch Drive
14. FATHER'S NAME First Middle Last WILLIAM DAWLEY		15. MOTHER'S MAIDEN NAME First Middle Last CATHERINE E. BROWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. 214-01-49768		17. INFORMANT Address R. R. 1, Catonsville	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac dilatation</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic myocarditis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Senility</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4222					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (the hospital) attended the deceased from 2/12/68, 19 to 2/25/68, 19, that (I) (we) last saw the deceased alive on 2/23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE A. Calais		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2/27/68	
22d. PHYSICIAN'S NAME (Type) A. CALAIS		22e. ADDRESS 6611 Frederick Ave			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-28-68		23c. NAME OF CEMETERY OR CREMATORY Catholick Cem.	
23d. LOCATION (City or Town) (County) (State) Baltimore Md.					
24. FUNERAL DIRECTOR Farley Caravage F.N. Catonsville		ADDRESS		25a. REC'D BY REGISTRAR DATE FEB 29 1968	
				25b. REGISTRAR'S SIGNATURE James J. Jones	



CERTIFICATE OF DEATH

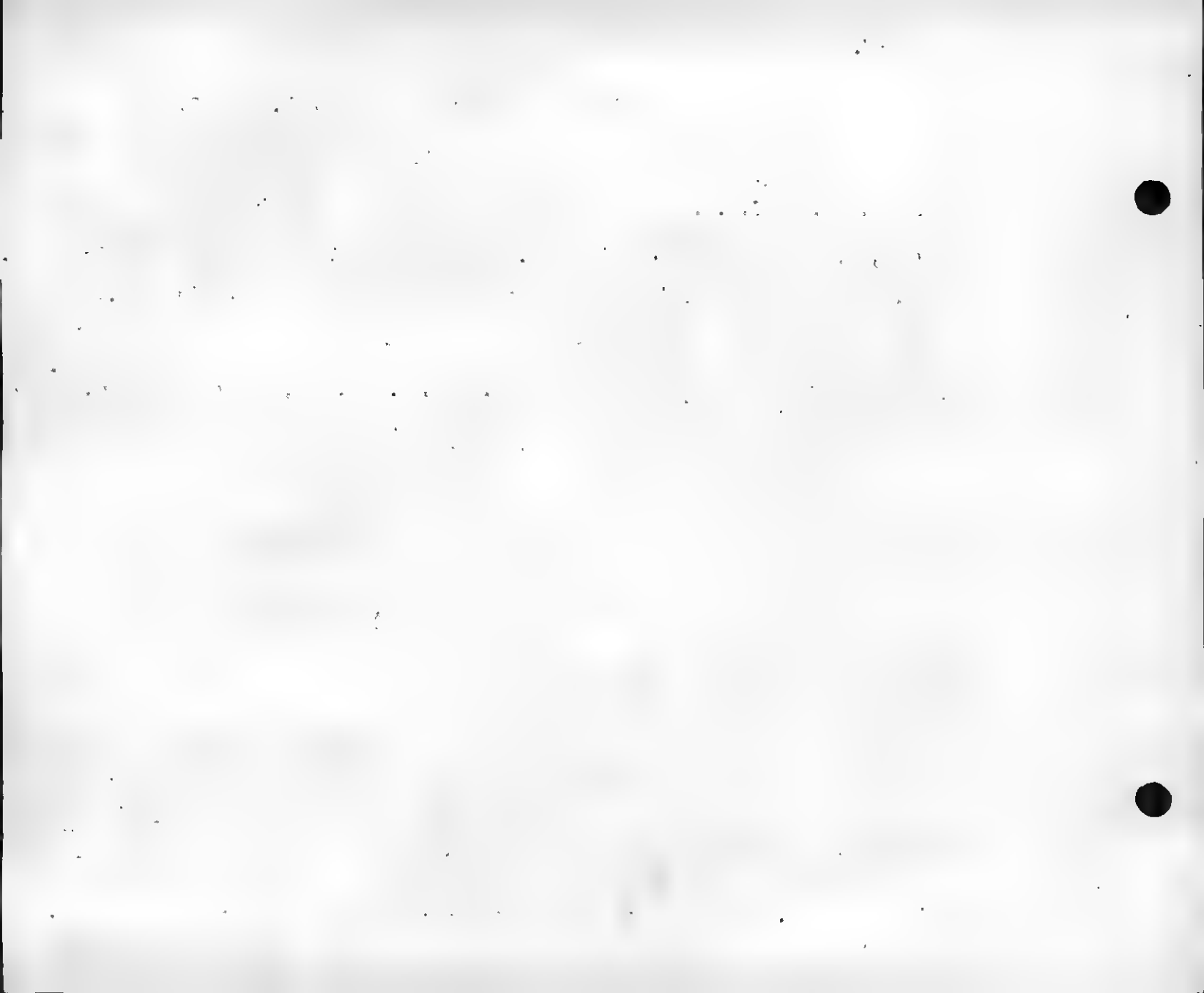
J215A

2147

1. DECEASED-NAME (Type or print) First Middle Last Joseph Harrison DeLaugh			2a. DATE OF DEATH Month Day Year Feb. 29 1968			2b. HOUR M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH July 4, 1898		6. AGE (In years last birthday) 69 YRS.	
7a. BIRTHPLACE (State or foreign country) Baltimore Co. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Towson, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 419 Woodbine Ave. Towson		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Service Salesman		12b. KIND OF BUSINESS OR INDUSTRY Ansley Inc.	
13a. USUAL RESIDENCE (Where deceased lived, if institution Res. dence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 419 Woodbine Ave.,		14. FATHER'S NAME First Middle Last Franklin Debaugh		15. MOTHER'S MAIDEN NAME First Middle Last Leora Gray			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (pg. or unknown) <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) None		16b. SOCIAL SECURITY NO. unknown		17. INFORMANT Address TOWSON, Md. Mrs. Agnes T. Debaugh, 419 Woodbine Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Two weeks</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Jan 19, 1963 to Jan 29, 1968, that (I) (we) last saw the deceased alive on Jan 29, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Ernest H. Green</u> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c. DATE SIGNED <u>2/2/68</u>			
22d. PHYSICIAN'S NAME (Type) <u>Bon Secours Hosp</u>				22e. ADDRESS <u>2025 W. Fayette St - Baltimore 23</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Feb. 5, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR <u>Frank H. Newell</u> ADDRESS <u>Pikesville, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 7 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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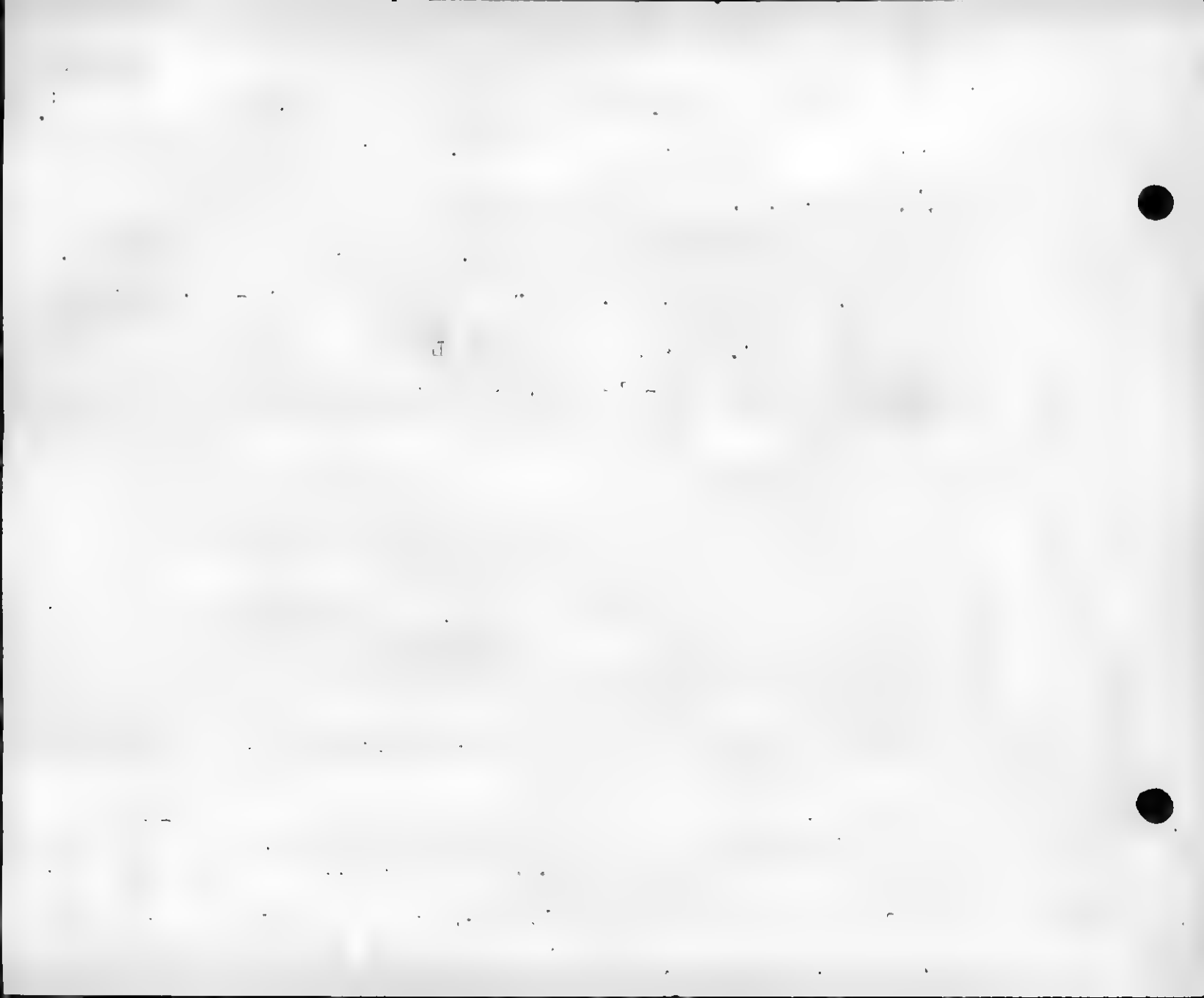
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VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) Clarence Evans Dedmon			2a. DATE OF DEATH Month February Day 5 Year 68			2b. HOUR 11:05 AM	
3 SEX male		4. RACE white		5 DATE OF BIRTH Nov. 12, 1897		6 AGE (In years last birthday) 70 YRS	
7a. BIRTHPLACE (State or foreign country) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md	
10. CITY OR TOWN OF DEATH Catonsville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) engineer		12b. KIND OF BUSINESS OR INDUSTRY Army Eng. Corp	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Pr. Geo.		13c CITY OR TOWN Berwyn		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 8605 - 63rd Avenue		14 FATHER'S NAME First Middle Last Albert J. Dedmon		15. MOTHER'S MAIDEN NAME First Middle Last Jeane Louiza Irvin			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown yes (* yes give war or dates of service)		16b SOCIAL SECURITY NO. 289-01-0936		17 INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 435X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED White <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No. City or Town County State			
22a I certify that (X) (this hospital) attended the deceased from Dec. 25, 1967 , to Feb. 5, 1968 , that (X) (we) lost saw the deceased alive on Feb. 5, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <i>Anthony J. Young</i> DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c DATE SIGNED 2-5-68	
22d. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228					
23a BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 2/8/68		23c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery		23d LOCATION (City or Town) (County) (State) Waynesboro, Pennsylvania	
24. FUNERAL DIRECTOR: <i>The S. H. Hines Co</i>		ADDRESS <i>2901-14th St. NW</i>		25a REC'D BY REGISTRAR DATE FEB 9 1968		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



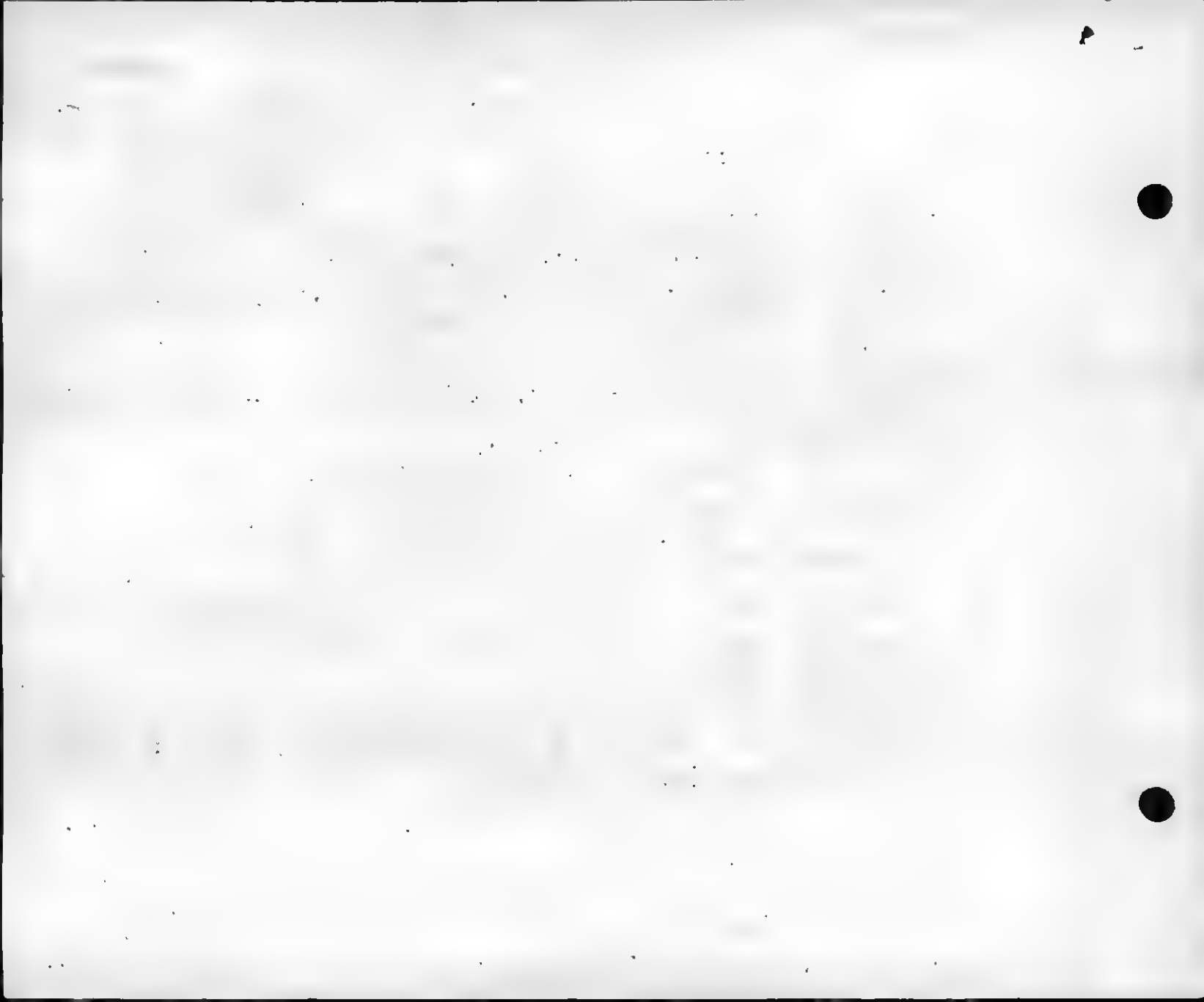
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VR A15 (4-5)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year	2b HOUR
JACOB				DEITZ	FEBRUARY 7, 1968	7:30 AM
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	7 UNDER 1 YEAR MONTHS DAYS	8 UNDER 24 HRS HOURS MIN
MALE	WHITE			87 YRS.		
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
LITHUANIA	U.S.A.			BALTIMORE Md		
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY	
PIKESVILLE	MILFORD MANOR NURSING HOME		MERCHANT		RETAIL	
13a USUAL RESIDENCE (Where deceased lived, if admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY (M 157) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER		
MARYLAND	BALTIMORE	PIKESVILLE		3506 OLD POST DRIVE #21208		
14 FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last				
LOUIS		DEITZ		?		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT Address		
NO				MR. VICTOR DEITZ, 3506 OLD POST DRIVE #21208		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cardio-Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF <u>Congestive Heart Failure</u> (b) <u>Arteriosclerotic CVD</u> DUE TO, OR AS A CONSEQUENCE OF <u>Carcinoma of Prostate & Metastasis</u> (c) <u>4129</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>July 3, 1967</u> , to <u>FEB 7, 1968</u> , that (I) (we) last saw the deceased alive on <u>FEB 7, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Willard Applefeld</u> M.D. 22d. PHYSICIAN'S NAME (Type)				22c. DATE SIGNED <u>2/7/68</u>		
22e. ADDRESS <u>5301 Park Heights Dr.</u>						
23a. BURIAL, CREMATION REMOVED (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)
BURIAL		2-8-68		BNAI ISRAEL		BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS., 6010 PEISTERSTOWN ROAD</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 9 1968</u>		25b. REGISTRAR'S SIGNATURE <u>George</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02161

02150

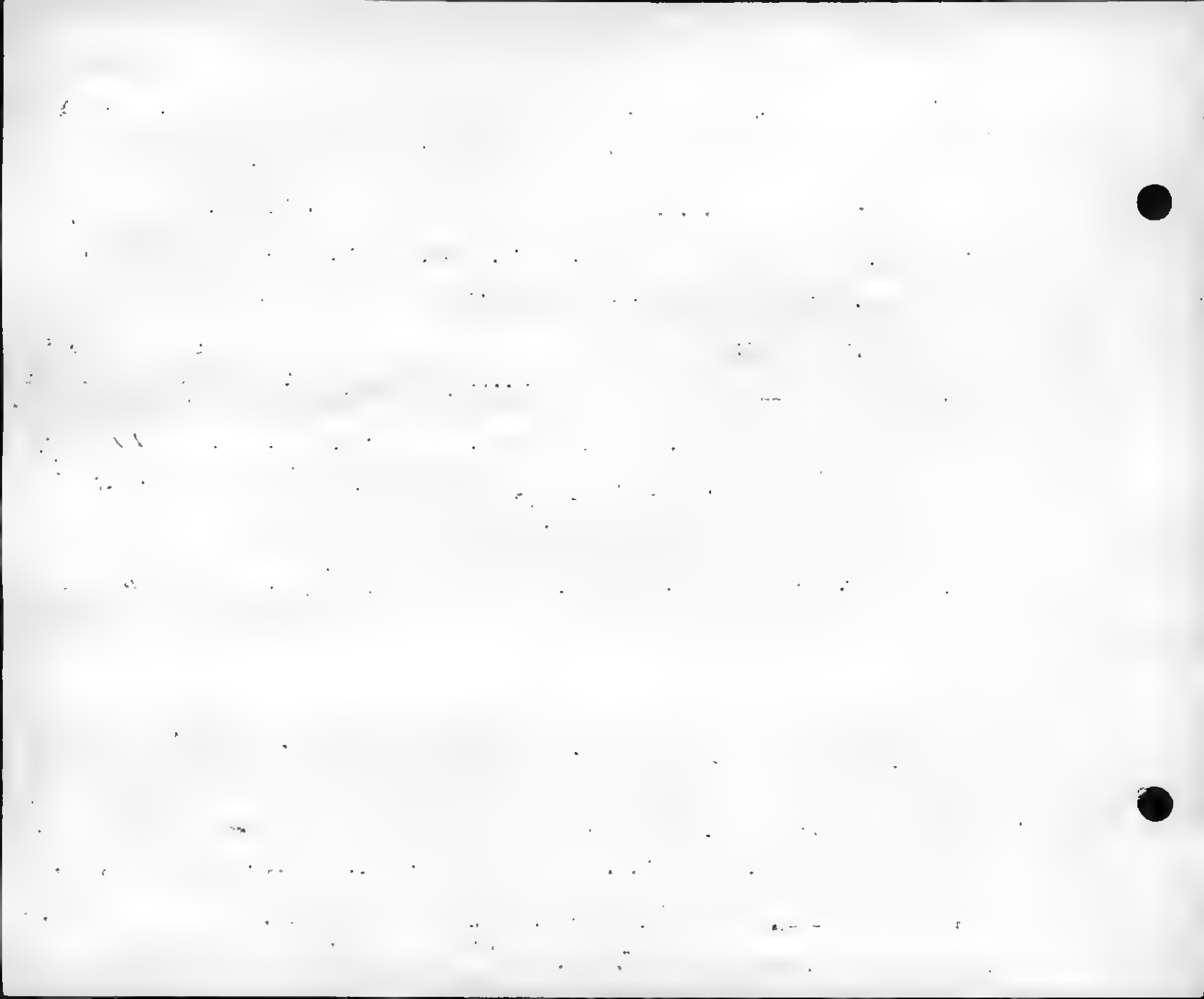
1 DECEASED NAME (Type or print) Werner			First Otto			Middle DIRKS			Last			2a DATE OF DEATH Month 2 Day 2 Year 68			2b HOUR 8:00 ^{AM}		
3 SEX Male			4 RACE White			5 DATE OF BIRTH 5/1/34			6 AGE (In years lost birthday) 33 YRS			IF UNDER YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN.		
7a BIRTHPLACE (Store or foreign country) Maryland			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md								
10 CITY OR TOWN OF DEATH Owings Mills			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rosewood St. Hosp.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Dependent			12b KIND OF BUSINESS OR INDUSTRY none								
13a USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE Md.			13b COUNTY Prince George			13c CITY OR TOWN Seat Pleasant			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET AND NUMBER 6905 B Street					
14. FATHER'S NAME First Bernd			Middle Jansen			Last Dirks			15 MOTHER'S MAIDEN NAME First Frances			Middle Christine			Last Kugler		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service)			16b SOCIAL SECURITY NO none			17. INFORMANT Address Rosewood Records, Owings Mills, Maryland											
18 CAUSE OF DEATH (Enter only one cause per line for (d), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxia DUE TO, OR AS A CONSEQUENCE OF (b) Aspiration of Stomach Contents DUE TO, OR AS A CONSEQUENCE OF (c) Orthostatic Bronchial Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4 yrs															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH terminal 14 days		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 10 stroke, 31 yrs due to syphilis																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (X) (this hospital) attended the deceased from 9/1 , 19 57 , to 2/2 , 19 68 , that (X) (we) last saw the deceased alive on 2/2 , 19 68 , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Richard A. Jones			DEGREE			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 2/5/68								
22d. PHYSICIAN'S NAME (Type) Richard A. Jones, M.D.			22e. ADDRESS Rosewood St. Hosp., Owings Mills, Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 2/7/68			23c. NAME OF CEMETERY OR CREMATORY Rosewood Cemetery			23d. LOCATION (City or Town) (County) (State) Owings Mills, Md.								
24. FUNERAL DIRECTOR J. F. Elire & Sons			ADDRESS Reisterstown, Md.			25a. REC'D BY REGISTRAR DATE FEB 9 1968			25b. REGISTRAR'S SIGNATURE W. W. Jones								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1 DECEASED NAME (Type or print)			First		Middle		Last		2a DATE OF DEATH			2b HOUR	
Patricia Lynn Doyle									2 Month Day 4 Year 68			8:30 ^{PM}	
3 SEX		4. RACE		5 DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		3/7/57				10 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Maryland			U.S.A.						Baltimore Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Owings Mills			Rosewood St. Hosp.						Dependent		none		
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIM. 157		13e. STREET AND NUMBER			
Maryland				Baltimore		Catonsville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1808 Alto Vista Avenue			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
First Middle Last				First Middle Last									
William Edward Doyle				Martha Ermin Rawleigh									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.				17. INFORMANT					
no				none				Mr. William Doyle, 1808 Alto Vista Ave, Catonsville, Md. Rosewood Hosp., Owings Mills, Maryland, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <i>Orthostatic bronchial pneumonia</i>													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <i>Aspiration of stomach contents</i>													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
<i>Profound mental retardation + Microcephaly</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		yes					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
		HOUR A.M. Month Day Year											
		P.M. 19											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION				City or Town County State					
at work <input type="checkbox"/>				Street or R.F.D. No.									
22a. I certify that (X) (this hospital) attended the deceased from 1/17, 1968, to 2/4, 1968, that (X) (we) last saw the deceased alive on 2/4, 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (do) (did not) view the body after death													
22b. SIGNATURE								DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED	
Richard A. Jones												2/5/68	
22d. PHYSICIAN'S NAME (Type)								22e. ADDRESS					
Richard A. Jones, M.D.								Rosewood St. Hosp., Owings Mills, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
Burial		2-7-68		Lorraine Park Cemetery				Balto. Md.					
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Witzke Funeral Directors, 4101 Edmondson Avenue, Balto., Md. 21229				FEB 7 1968				[Signature]					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12163

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) VIERIS			First Middle Last			2a. DATE OF DEATH Month FEBRUARY Day 2 Year 1968			2b. HOUR 2-A M								
3 SEX FEMALE			4 RACE WHITE			5 DATE OF BIRTH			6 AGE (in years last birthday) 83 YRS			F. UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) NEW ORLEANS, LA.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE			Md.					
10. CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) PROFESSIONAL HOUSE			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSE WIFE			12b. KIND OF BUSINESS OR INDUSTRY AT HOME								
13a. USUAL RESIDENCE (Where deceased lived, if not in hospital give street address) STATE MARYLAND			13b. COUNTY BALTIMORE			13c. CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 6309 WIRT AVENUE					
14. FATHER'S NAME First Middle Last SIMON			15. MOTHER'S MAIDEN NAME First Middle Last JOSEPHINE BENSADEN														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) NO			16b. SOCIAL SECURITY NO.			17. INFORMANT MR. LAWRENCE GOLDBLOOM			Address 6309 WIRT AVE. #21215								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF (b) Coronary arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last 1109												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH connect. 1-2 yrs					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 1-17 , 19 58 , to 2-2 , 19 68 , that (I) (we) last saw the deceased alive on 1-24 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Irvin Sauber			22c. DATE SIGNED 2-4-68			22d. PHYSICIAN'S NAME (Type) IRVIN SAUBER			22e. ADDRESS 6505 Clark Heights			22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 2-4-68			23c. NAME OF CEMETERY OR CREMATORY ELKVIEW MASONIC			23d. LOCATION (City or Town) (County) (State) CLARKSBURG, WEST VIRGINIA								
24. FUNERAL DIRECTOR SOL LEVINSON & BROS.			ADDRESS 6010 REISTERSTOWN ROAD			25a. REC'D BY REGISTRAR DATE FEB 6 1968			25b. REGISTRAR'S SIGNATURE Charles Judge								



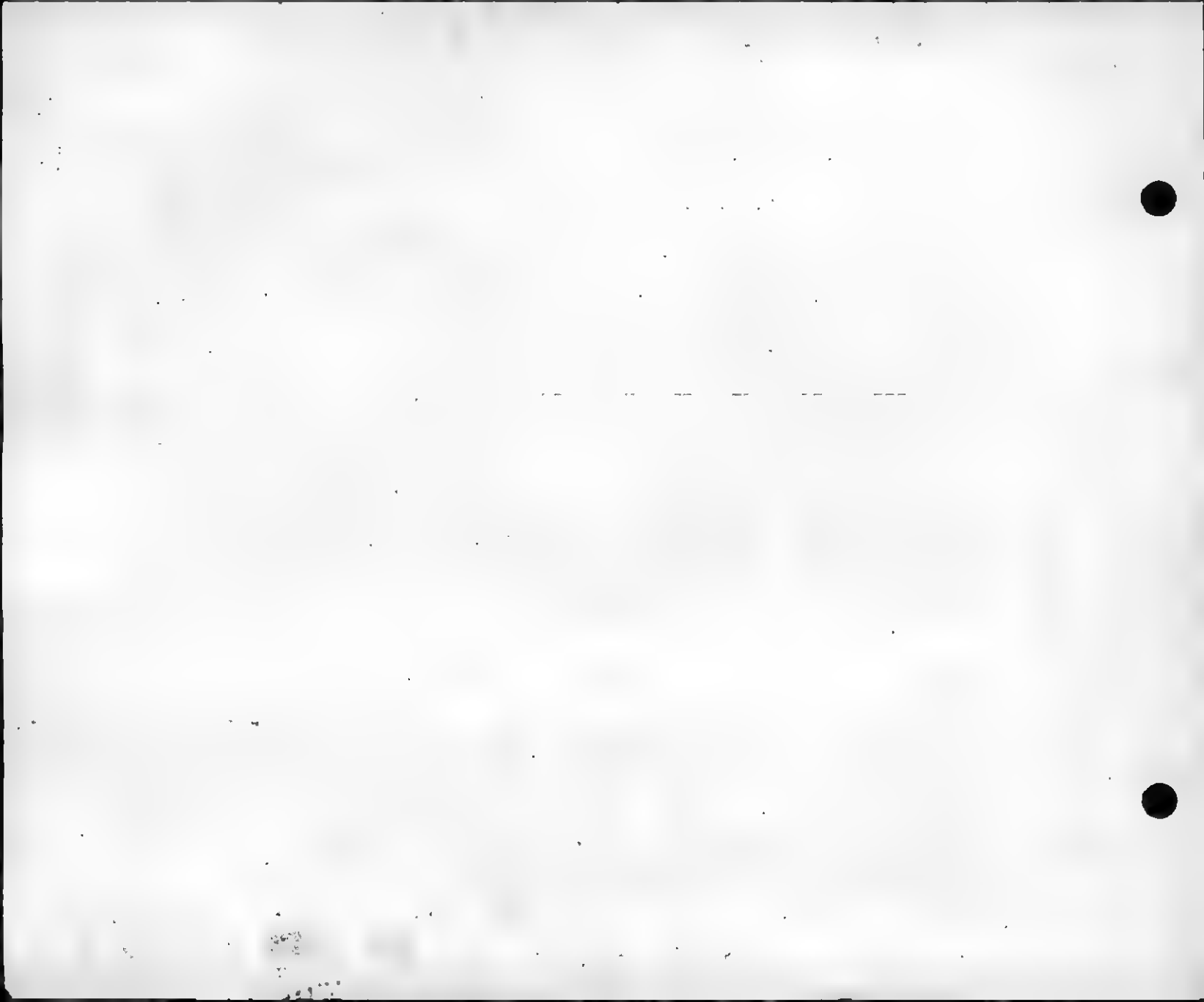
FOR STATE HEALTH DEPT

any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PH-3. Page 5 may be retained for your files.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																	
1. DECEASED NAME (Type at Print)			First CLAIRE			Middle MARIE			Last DUFFY			2a. DATE KNOWN OF DEATH Month Day Year Feb 29 1968			2b. HOUR OF ESTIMATED DEATH P. M. 9:30		
3 SEX Female		4 RACE Cau.		5 DATE OF BIRTH Dec. 30, 1959		6 AGE (in years last birthday) 8 YRS		if UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD Month Day Year Feb 29 1968			2d. HOUR P. M. 9:30		
7a. BIRTHPLACE (State or foreign country) New Jersey				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH BALTIMORE Md					
10. CITY OR TOWN OF DEATH Towson				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) Student				12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland				13b. COUNTY Baltimore				13c. CITY OR TOWN Cockeysville				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 10515 York Ave.			
14. FATHER'S NAME First Middle Last Charles J. Duffy						15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth Malarkey											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b. SOCIAL SECURITY NO (If yes give war or dates of service)				17. INFORMANT Charles J. Duffy.				ADDRESS Same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Severe Shock, due to exanguinating intre-abdominal hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rupture of liver, both kidneys and right lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Laceration of inferior vena cava</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>1124</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19a. DATE OF OPERATION Feb 29 1968				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? MULTIPLE INJURIES				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month Day Year HOUR MIN 5:45 P.M. 2/29 1968				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Hit by Automobile									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) STREET				21f. LOCATION Street or R.F.D. No City or Town County State WARREN RD. COCKEYSVILLE BALTO. MD.									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE William A. Pillsbury				M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASS STANT MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) William A. Pillsbury								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, City, State, or County) 3-1-68					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE Mar. 4, 1968				23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cemetery				23d. LOCATION (City or Town) (County) (State) Cockeysville, Maryland					
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road, Towson, Md. 21204								25a. REC'D BY REGISTRAR MAR 4 1968		25b. REC'D BY S.S. JUDGE John S. Judge							

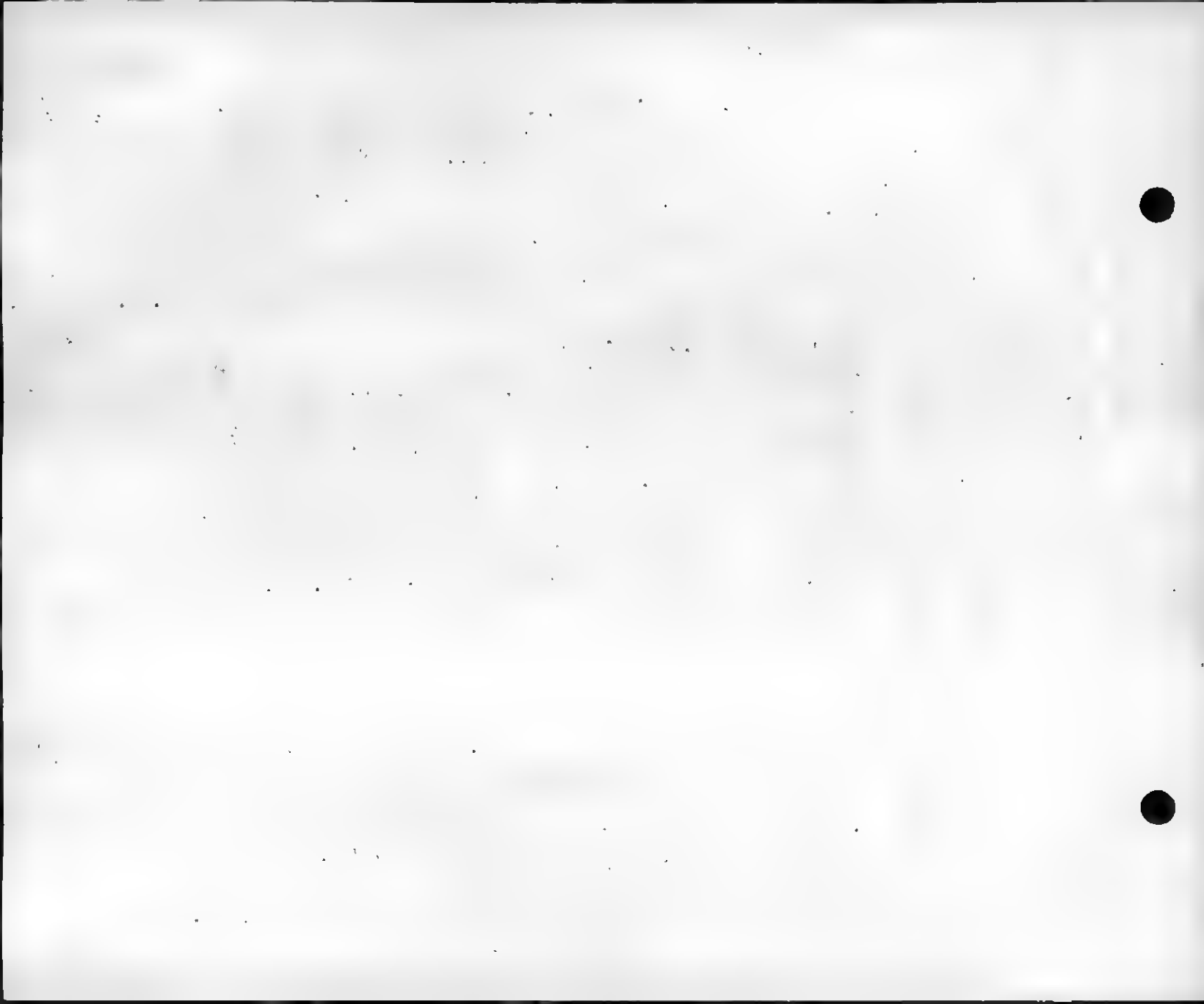


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 6 Film G398
3/4/68 ap 02165
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH		2b. HOUR	
Louis DUNGAN					2 - 24 - 68		6 P. M.	
3 SEX	M	4 RACE	W	5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 24 HRS
				Sept. 23, 1879		79 YRS.		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		
Baltimore, Md.						Baltimore		Md
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Holbrook		CHAPEL HILL M.H.		Retired - Civil Service				
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
Maryland		Baltimore		Holbrook				Chapel Hill N. H.
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle
Stevenson				Archer Dungan	Dempster			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown)		16b. SOCIAL SECURITY NO		17 INFORMANT		Address		
				Mr. Carl Heinmiller				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarct								
4109 DUE TO, OR AS A CONSEQUENCE OF ASCVD								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								
DUE TO, OR AS A CONSEQUENCE OF								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
Generalized Arteriosclerosis - Senility								
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from 8-25-1965, to 2-24-1968, that (I) (we) last saw the deceased alive on 2-24-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE Cesar Valle Caverio						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-24-68
22d PHYSICIAN'S NAME (Type) CESAR VALLE CAVERO						22e. ADDRESS 8624 Liberty Rd		
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 2/27/68		23c NAME OF CEMETERY OR CREMATORY Green Mount Cemetery		23d LOCATION (City or Town) Baltimore, Md.		(County) (State)
24 FUNERAL DIRECTOR Wm. F. T. ...				ADDRESS Baltimore, Md.		25a. REC'D BY REGISTRAR DATE FEB 29 1968		25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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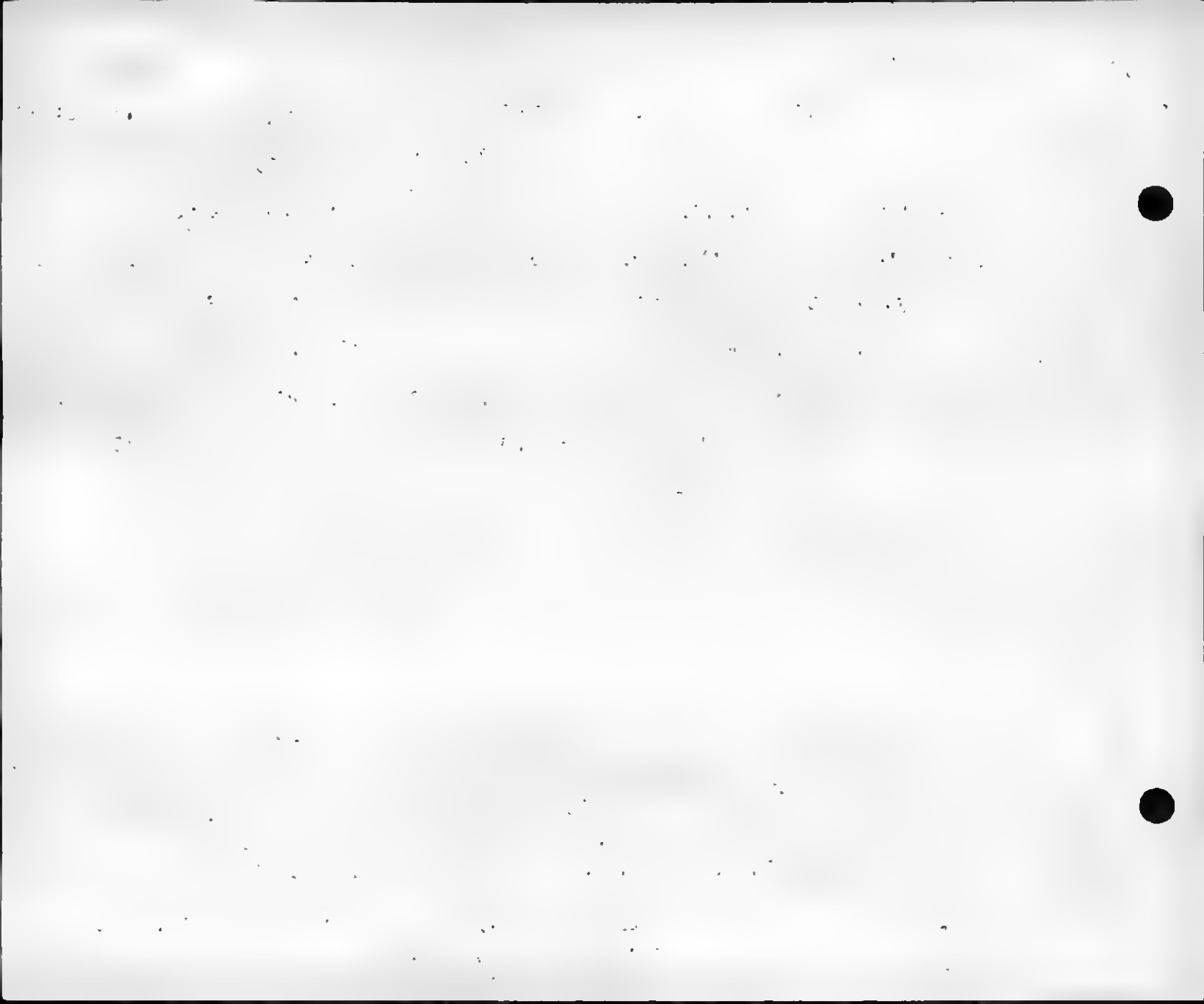


MD 21-155
MAY 1968

22166

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
THOMAS		E.		DUNMAN	FEBRUARY 6 1968		3:15 PM	
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
MALE	WHITE		8/19/12		55 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH		
VIRGINIA		U.S.A.				BALTIMORE COUNTY, Md		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
FORT HOWARD		VET. ADM. HOSPITAL		CARPENTER		CONSTRUCTION		
13a. USUAL RESIDENCE (Where deceased lived, admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
MARYLAND		ANNE ARUNDEL		PASADENA				BOX 95, Route 10
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last				
WILLIS W. DUNMAN				LULA M. WATTS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17 INFORMANT Address				
YES		WW II		225 10 67 23 CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:								MINUTES
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION								
410.7 DUE TO, OR AS A CONSEQUENCE OF								
(b) CORONARY OCCLUSION								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (X) (this hospital) attended the deceased from 1/31/68, 19, to 2/6/68, 19, that (X) (we) last saw the deceased alive on 2/6/68, 19, and that in (NY) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (and) (not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)				
		2/7/68		KRISHNA V. S. RAO, M. D.				
22e. ADDRESS		22f. ADDRESS						
		VAH FORT HOWARD, MARYLAND						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL				MEADOWRIDGE CEMETERY		GLEN BURNIE, MD.		
24. FUNERAL DIRECTOR		25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
C.B. Fleming		FEB 8 1968		J. J. Judge				
200 CRAIN HIGHWAY, GLEN BURNIE, MD.								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD 156
2164
MAY 1968
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) CHARA A. DUNNIGAN DONEGAN-DUNEGAN			2a. DATE OF DEATH Month 8 - Day 11 - Year 68			2b. HOUR 6:25 PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH OCT. 28, 1880		6. AGE (In years last birthday) 87 YRS	
7a. BIRTHPLACE (State or foreign country) PENNA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE COUNTY Md.	
10. CITY OR TOWN OF DEATH OVERLEA		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 119 WEST ELM AVE.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSE WIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN OVERLEA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 119 WEST ELM AVENUE							
14. FATHER'S NAME First Middle Last JOSEPH Mc. CUSKER			15. MOTHER'S MAIDEN NAME First Middle Last MARY CREIG				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) NO			16b. SOCIAL SECURITY NO WA 366922		17. INFORMANT Address THERESA REZAC 119 WEST ELM AVENUE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute Coronary Thrombosis. 4107 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) ? Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 2/9, 1968 , to 2/9, 1968 , that (I) (we) last saw the deceased alive on 2/9, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. Sadarananda M.D.				DEGREE MD ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2/11/68	
22d. PHYSICIAN'S NAME (Type) V. SADARANANDA				22e. ADDRESS 6801 BELAIR ROAD BALTO MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 2-15-1968		23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL CEMETERY		23d. LOCATION (City or Town) (County) (State) OLD FEDERICK RD BALTIMORE MD	
24. FUNERAL DIRECTOR THE DIPEL BROTHERS 710 BELAIR ROAD				25a. REC'D BY REGISTRAR FEB 15 1968		25b. REGISTRAR'S SIGNATURE [Signature]	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1-2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-10. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

2168 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print) <i>Mary Emmaline</i>			First <i>EDWARDS</i>			Middle			Last		
2a DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> Month <i>2</i> Day <i>2</i> Year <i>1968</i>		2b HOUR <i>10:30 PM</i>		2c DATE PRONOUNCED DEAD		Month <i>2</i> Day <i>2</i> Year <i>1968</i>		2d HOUR <i>11 PM</i>	
3 SEX <i>F</i>	4 RACE <i>W</i>	5 DATE OF BIRTH <i>3/18/85</i>	6 AGE (in years last birthday) <i>82</i> YRS	IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>		IF UNDER 24 HRS HOURS <i>0</i> MIN <i>0</i>					
7a BIRTHPLACE (State or foreign country) <i>Virginia</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i> Md					
10 CITY OR TOWN OF DEATH <i>Lansdowne</i>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>164 Stafford St.</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>			12b KIND OF BUSINESS OR INDUSTRY <i>-</i>		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>MD.</i>			13b COUNTY <i>Balto.</i>			13c CITY OR TOWN <i>Lansdowne</i>			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME First <i>Jerry</i> Middle <i>P.</i> Last <i>Vass</i>			15. MOTHER'S MAIDEN NAME First <i>Lucetta</i> Middle <i>Webb</i> Last <i>Webb</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No</i>			16b. SOCIAL SECURITY NO			17. INFORMANT ADDRESS <i>Mrs. Emma V. Morlock, 5509 Alban Ave. #14</i>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardio-Vascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>U.I.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diabetes mellitus</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. <i>19</i> P.M.			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No <i>1311 Francis Ave</i> City or Town <i>Balto.</i> County <i>MD</i> State <i>MD</i>					
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>James N. Frederick</i>			EXAMINER'S NAME (Type) <i>James N. Frederick</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b DATE SIGNED <i>2/2/68</i> ADDRESS (Street, city, town, or county) <i>1311 Francis Ave Balto. Md 21222</i>		
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>2/6/68.</i>			23c NAME OF CEMETERY OR CREMATORY <i>Belair Memorial Cemetery</i>			23d LOCATION (City or Town) <i>Baltimore, Md.</i> (County) (State)		
24 FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc. Balto. Md. 21214</i> ADDRESS						25a REC'D BY REGISTRAR <i>FEB 5 1968</i> DATE			25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



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Item 18 fillm 398 2-26-68 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
02169
CERTIFICATE OF DEATH

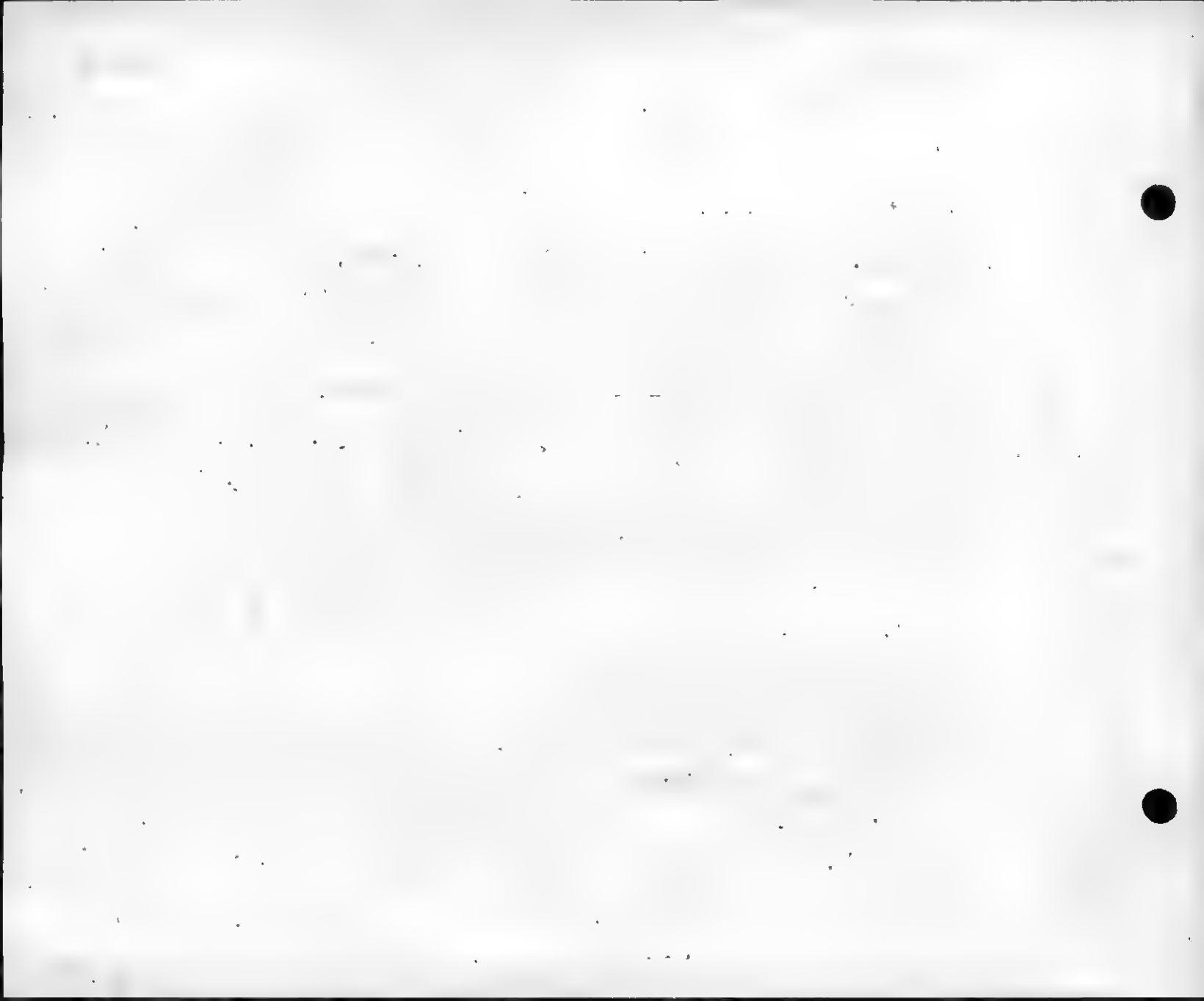
1. DECEASED-NAME (Type or print) TIMOTHY W. EDWARDS			2a. DATE OF DEATH FEB Month 8 Day 1968 Year		2b. HOUR M	
3. SEX M	4. RACE W	5. DATE OF BIRTH 2/28/92		6. AGE (in years last birthday) 75 YRS.	7. UNDER 1 YEAR MONTHS DAYS	8. UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) VA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTO.		12b. KIND OF BUSINESS OR INDUSTRY MARTIN CO	
10. CITY OR TOWN OF DEATH ESSEX		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 362 LEEANNE RD		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		
13a. USUA. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD	13b. COUNTY BALTO.	13c. CITY OR TOWN ESSEX	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 362 LEEANNE RD		
14. FATHER'S NAME First Middle Last TIMOTHY H. EDWARDS		15. MOTHER'S MAIDEN NAME First Middle Last ?				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NK (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 215-10-3538		17. INFORMANT MAE EDWARDS Address ABOVE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 12X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Parkinson DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 1965 , 19____, to 1968 , 19____, that (I) (we) last saw the deceased alive on 2-6 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death						
22b. SIGNATURE Leopoldo Gross DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c. DATE SIGNED 2-8-68		
22d. PHYSICIAN'S NAME (Type) Leopoldo Gross		22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 2/10/68		23c. NAME OF CEMETERY OR CREMATORY MORELANDS		
23d. LOCATION (City or Town) (County) (State) BALTO. MD						
24. FUNERAL DIRECTOR J.B. CONNELLY SONS		ADDRESS 300 MACE		25a. REC'D BY REGISTRAR DATE FEB 13 1968		
25b. REGISTRAR'S SIGNATURE						



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CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) Roy		Middle R.		Last England		2a. DATE OF DEATH Month Feb Day 11 Year 1968		2b. HOUR 8.25	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Oct 20, 1889		6. AGE (In years last birthday) 78 YRS		IF UNDER YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore		2b. HOUR Md	
10. CITY OR TOWN OF DEATH rural Balto.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6910 Digby Road		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Sales Specialist		12b. KIND OF BUSINESS OR INDUSTRY Auto.			
13a. USUAL RESIDENCE (Where deceased lived, if not in institution or residence before admission) STATE Maryland		13b. COUNTY Balto		13c. CITY OR TOWN rural Balto		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 6910 Digby Road	
14. FATHER'S NAME First Thomas		Middle England		Last Knight		15. MOTHER'S MAIDEN NAME First Henrietta		Middle Knight	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 216-03-7133		17. INFORMANT Mrs Estelle England		Address 6910 Digby Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Adenocarcinoma of the rectosigmoid 1041 DUE TO, OR AS A CONSEQUENCE OF (b) & Carcinoma of the prostate Conditions if any, which gave rise to immediate cause (a) stating the underlying cause last. 154x DUE TO, OR AS A CONSEQUENCE OF (c) terminal uremia PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Hypertension - Asymptomatic cardiovascular disease									
19a. DATE OF OPERATION July 1967		19b. CONDIT. ON FOR WHICH OPERATION WAS PERFORMED Above		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (if either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> hot while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 7-14 , 19 67 , to 2-11 , 19 68 ; that (I) had lost saw the deceased alive on 2-9 , 19 68 , and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) was (did) not view the body after death.									
22b. SIGNATURE M Davis		DEGREE Dr. Marvin Davis		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-13-68			
22d. PHYSICIAN'S NAME (Type) Dr. Marvin Davis		22e. ADDRESS 6512 Liberty Rd. Balto Md 21207							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/14/68		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION (City or Town) (County) (State) Pikesville Balto Md			
24. FUNERAL DIRECTOR Wm. J. Brown		ADDRESS 8725 Liberty Rd		25a. REC'D BY REGISTRAR DATE FEB 16 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

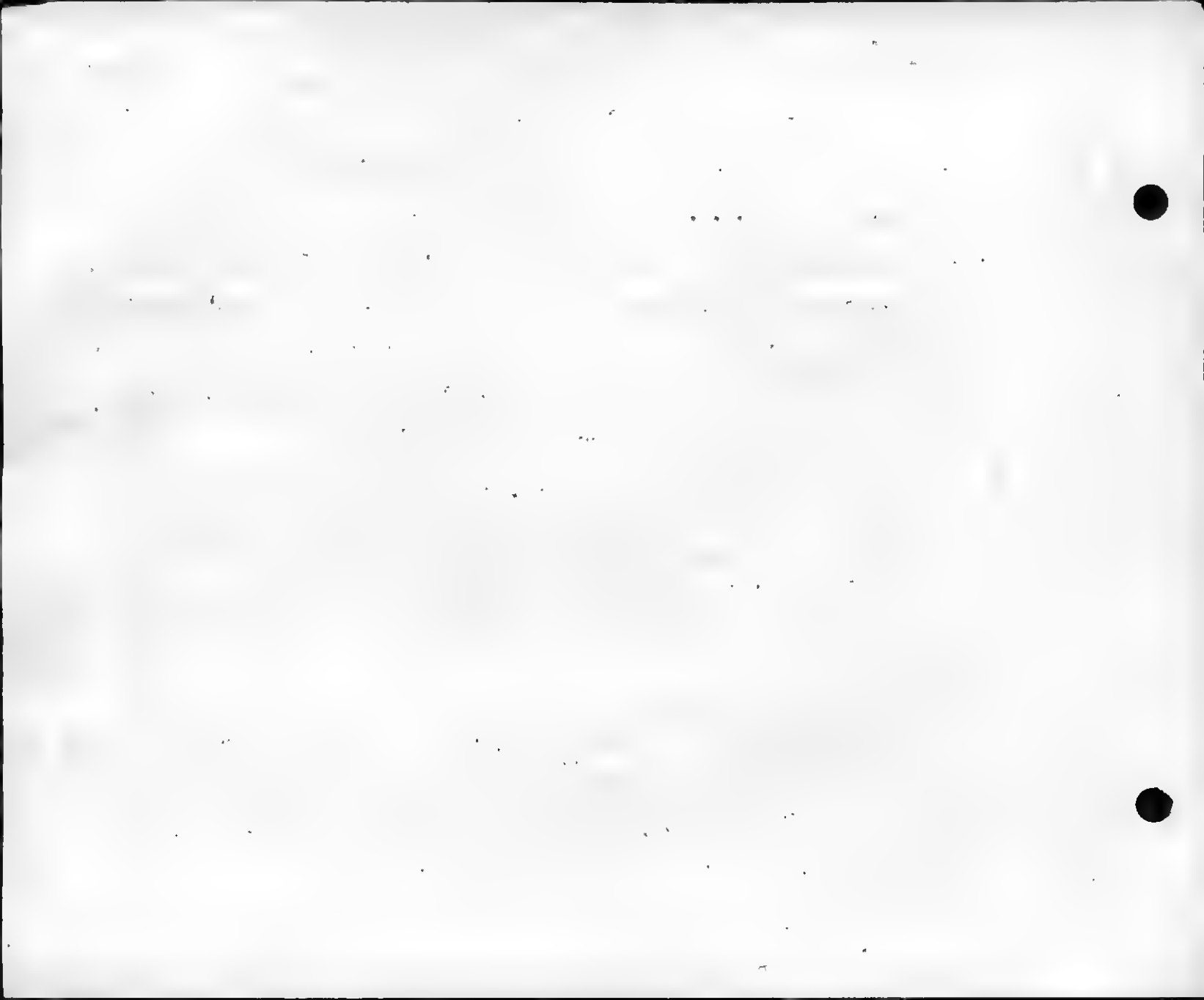


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR
Marie		Anna	Engleberth	2 9 68		7:05P M	
3 SEX	4. RACE		5. DATE OF BIRTH		6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Female	Cau		3-18-1895		72 YRS.		
7a. BIRTH-PLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Maryland	U.S.A.				Baltimore Md.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore	Greater Baltimore Med. Center		Housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY - WTS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER	
Maryland		Baltimore			Engelberth Ave		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last				
Harry Creamer			Margaret Ott				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
No				Mr William F Engelberth 111 Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary infarct							
DUE TO, OR AS A CONSEQUENCE OF (b) Multiple pulmonary emboli							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
Necrotizing pancreatitis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1/19, 1968, to 2/9/68, 1968, that (I) (we) last saw the deceased alive on 2/9, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>R. Breitenecker</i>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 2/10/68	
22d. PHYSICIAN'S NAME (Type) R. Breitenecker, M.D.				22e. ADDRESS 6701 N. Charles Street			
23a. BURIAL, CREMATION, REMOVAL, (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		2/14/68		Parkwood		Baltimore Maryland	
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REG. STRAR DATE FEB 13 1968		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
Leonard J Ruck Inc 5305 Harford Rd							



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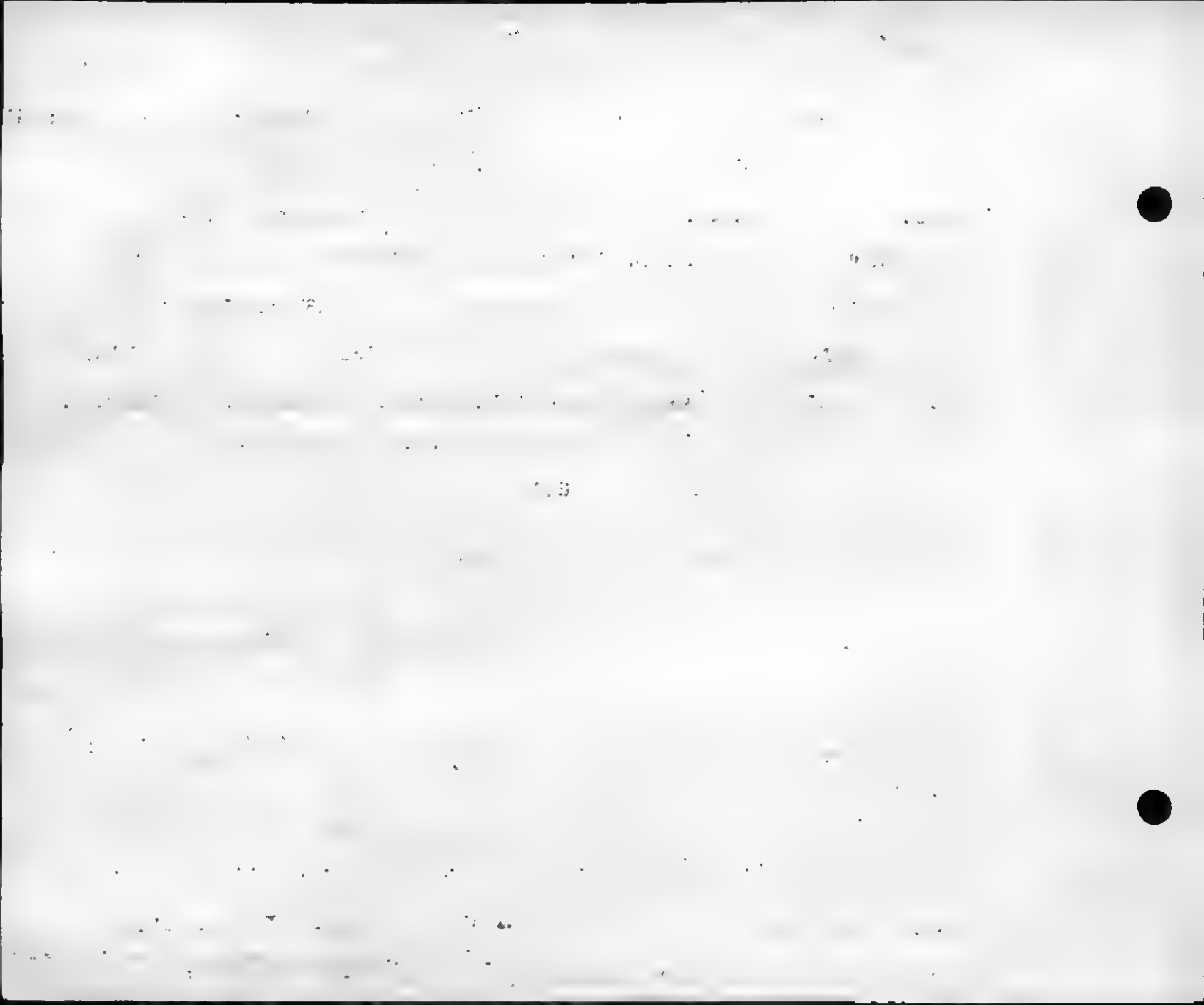
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VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
LEWIS (Louis) R.				EPPS	FEBRUARY 14 1968		12:45 PM	
3 SEX	4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
MALE	NEGRO		3/4/16		51 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
VIRGINIA		U.S.A.				BALTIMORE COUNTY, Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
FORT HOWARD		VET. ADM. HOSPITAL		LABORER		SCHOOL		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
MARYLAND				BALTIMORE				131 AISQUITTH STREET
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
First Middle Last			First Middle Last					
RUFUS EPPS			SUE BROWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
YES		WW II		213 07 60 66		CLIN. RECORDS, VA HOSPITAL, FT HOWARD MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
METASTATIC CARCINOMA IN LIVER AND LYMPH NODE								
CARCINOMA OF RECTUM								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (H) (this hospital) attended the deceased from 12/20/67, 19, to 2/14/68, 19, that (H) (we) last saw the deceased alive on 2/14/68, 19, and that in (H) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (do not) view the body after death.								
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS				
KRISHNA V. S. RAO, M. D.				VAH FORT HOWARD, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL		2-19-68		BALTIMORE NATIONAL		BALTIMORE, MARYLAND		
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
				MORTEN & DYETTE FUNERAL HOME		DATE FEB 16 1968		Charles Judge
				1701 Laurens St. Baltimore, Md.				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

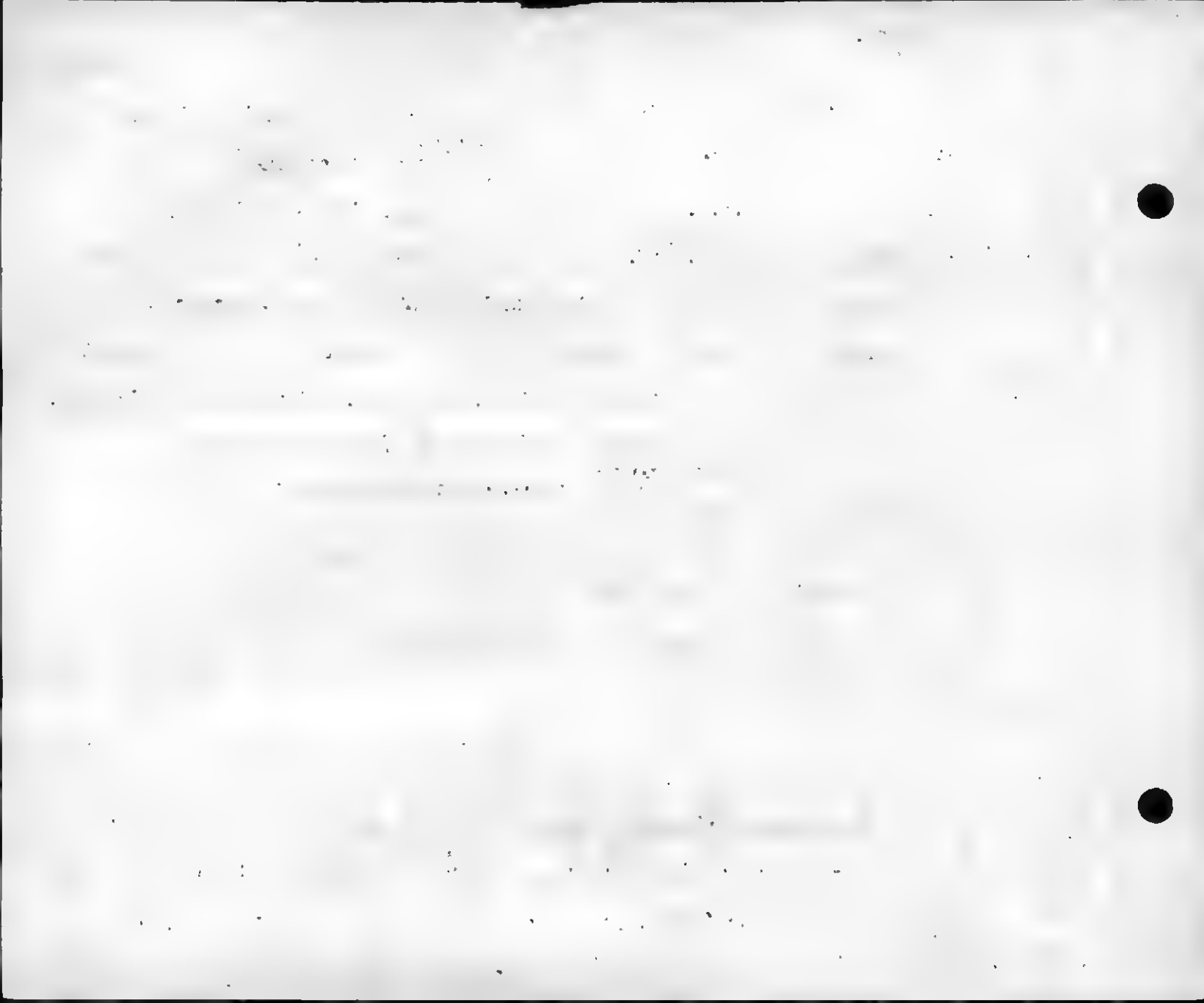
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

2173
M
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

2162

1. DECEASED-NAME (Type or print)		First JAMES		Middle W.	Last FANNIN	2a. DATE OF DEATH Month Day Year FEBRUARY 14 1968		2b. HOUR 5:55AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 11/6/13 11/5/1912		6. AGE (In years last birthday) 55 YRS		7. UNDER 24 HRS MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) KENTUCKY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE COUNTY, Md.			
10. CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. ADM. HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life even retired) GRAVE DIGGER		12b. KIND OF BUSINESS OR INDUSTRY CEMETERY			
13a. USUAL RESIDENCE (Where deceased lived f inst tuton Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 822 W. Lombard Street	
14. FATHER'S NAME First Middle Last JAMES EDWARD FANNIN		15. MOTHER'S MAIDEN NAME First Middle Last SALLIE CALLAHAN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) YES WW II		16b. SOCIAL SECURITY NO. 403 09 07 88		17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LOBAR PNEUMONIA, MASSIVE LUNG</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>470x</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARCINOMA OF PROSTATE WITH METASTASIS TO SPINE</u> (c) <u>IMMEDIATE CONSEQUENCE OF</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>ARTERIOSCLEROSIS, GENERALIZED</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (th.s hospital) attended the deceased from <u>2/13/68</u> , 19 <u> </u> , to <u>2/14/68</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>2/14/68</u> , 19 <u> </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Ahmed Kutty</u>		22c. DATE SIGNED 2/14/68		22d. PHYSICIAN'S NAME (Type) AHMED C. K. KUTTY, M. D.					
22e. ADDRESS VAH FORT HOWARD, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 2/16/1968		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR <u>John J. Brown + Son Inc.</u>		ADDRESS 901 COWAN FUNERAL HOME		25a. REC'D BY REGISTRAR DATE FEB 16 1968		25b. REGISTRAR'S SIGNATURE <u>Charles J. ...</u>			
		HOLLINS & POPPLETON STS. BALTIMORE, MD.		23					



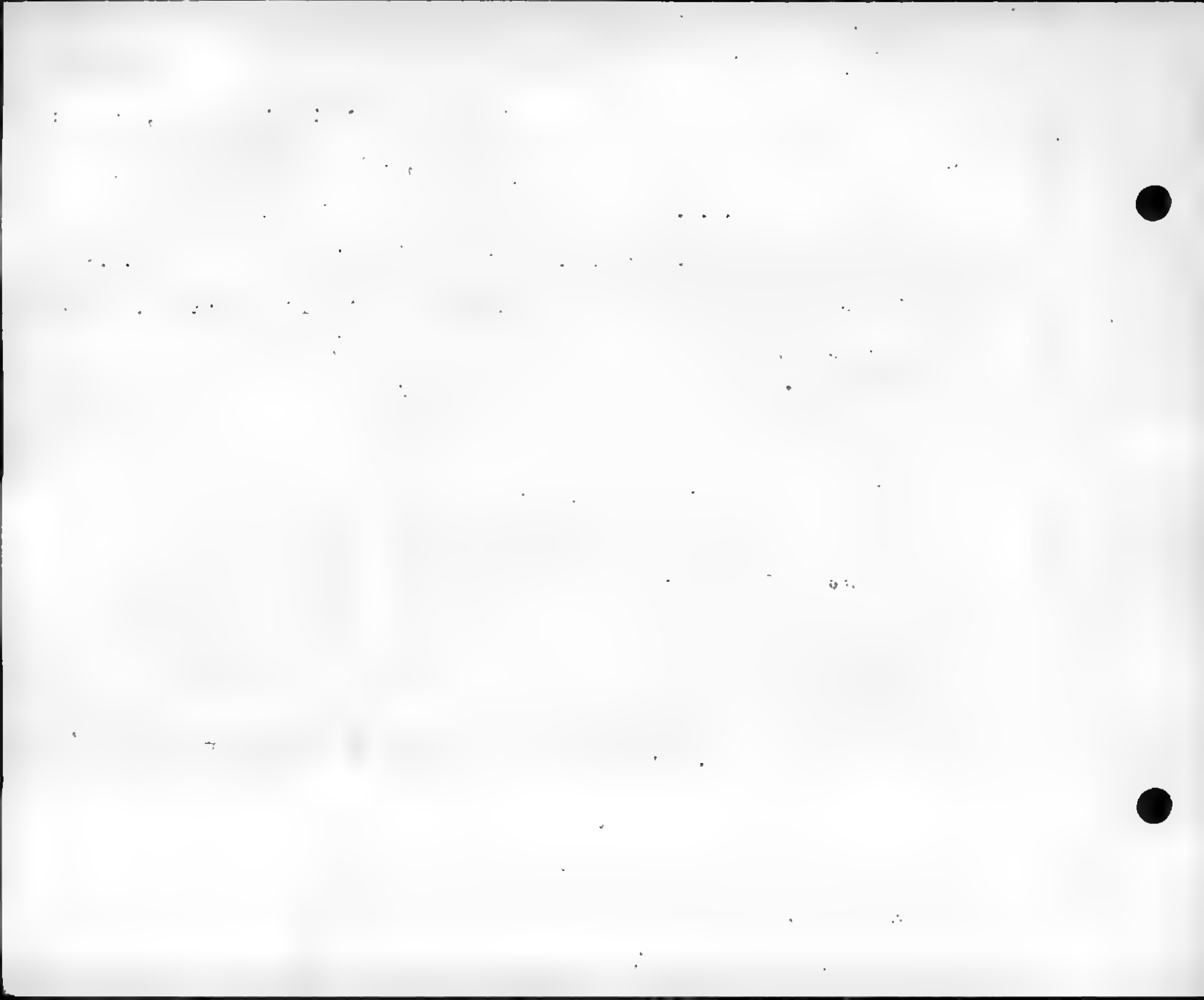
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

2174
2163
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #5 Film G **CERTIFICATE OF DEATH**

1 DECEASED NAME (Type or print) First Middle Last ROBERT ARNOLD FERBER			2a. DATE OF DEATH Month Day Year FEBRUARY 5 1968		2b. HOUR 9:30 M
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH August 7, 1918		6. AGE (In years lost birthday) 49 YRS.	
7a. BIRTHPLACE (State or foreign country) NEW JERSEY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 COUNTY OF DEATH BALTIMORE		10. CITY OR TOWN OF DEATH TOWSON			
11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) dist. mch. mdr		12b. KIND OF BUSINESS OR INDUSTRY U.S. STEEL	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE	13c. CITY OR TOWN LUTHERVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 19 CROFTLEY RD. #21093
14. FATHER'S NAME First Middle Last Norman C. Ferber			15. MOTHER'S MAIDEN NAME First Middle Last Charles A. Smith		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. 11		17 INFORMANT F. Misanik Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gram negative bacteriemia 455 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 467 X (b) hemorrhoidectomy DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Acute suppurative prostatitis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) (Office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (this hospital) attended the deceased from FEBRUARY 3, 1968 , to February 5 1968 , that (I) (we) last saw the deceased alive on FEBRUARY 5 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Lawrence F. Misanik DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22c. DATE SIGNED February 6, 1968
22d. PHYSICIAN'S NAME (Type) Lawrence F. Misanik, M.D.					22e. ADDRESS 7620 York Rd., Towson, Md. 21204
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Feb. 8, 1968		23c. NAME OF CEMETERY OR CREMATORY Lutheville burial	
23d. LOCATION (City or Town) (County) (State) Lutheville, Md.		24. FUNERAL DIRECTOR John Misanik, Towson, Md. ADDRESS			
25a. REC'D BY REGISTRAR FILE 5		25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE 8 1968	



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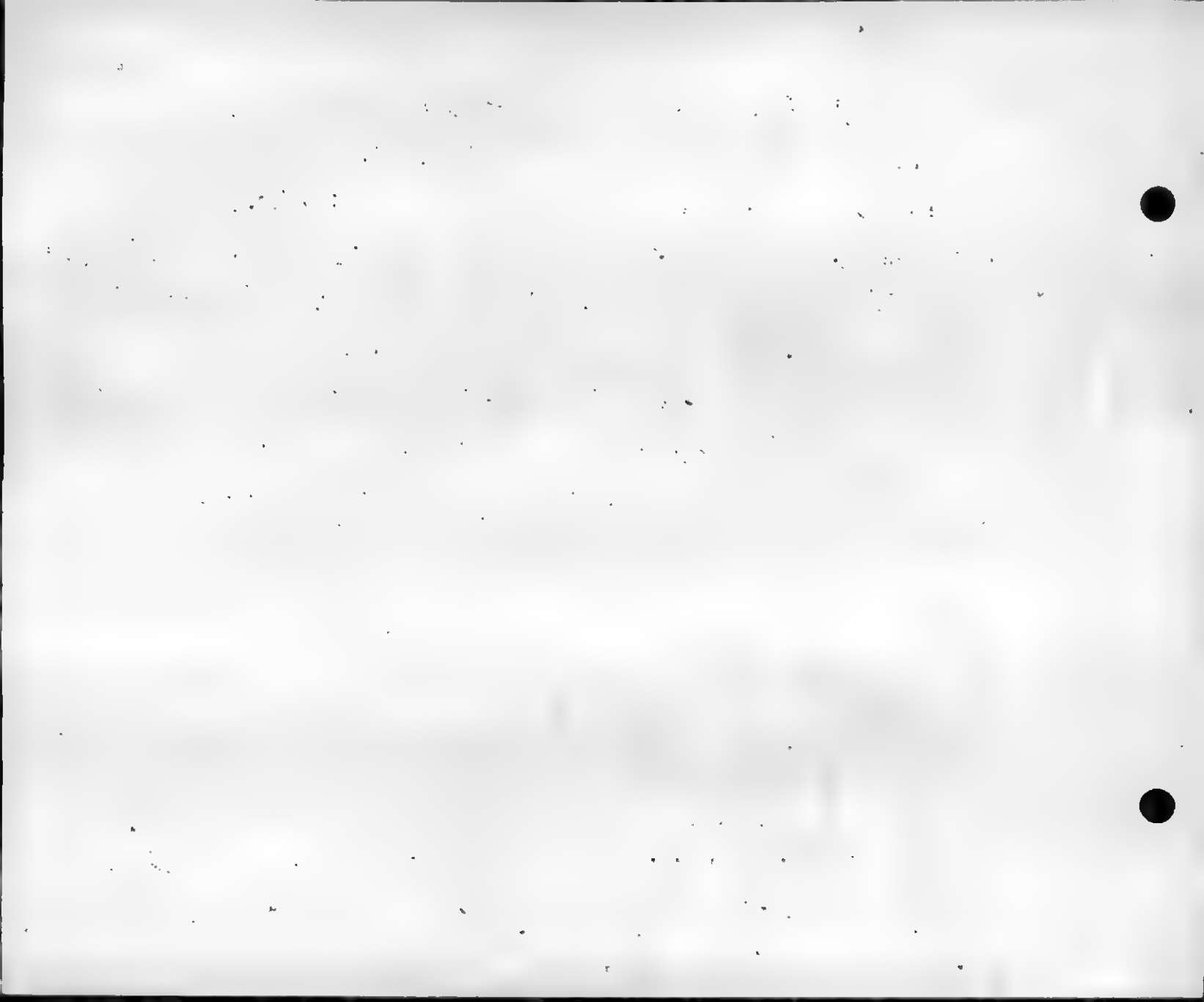
VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02164

1. DECEASED-NAME (Type or print) First Middle Last <i>Barbara P. Fink</i>		2a. DATE OF DEATH Month Day Year <i>2 2 68</i>		2b. HOUR 10 A M
3. SEX <i>Female</i>	4. RACE <i>white</i>	5. DATE OF BIRTH <i>12/26/1873?</i>	6. AGE (In years last birthday) <i>94</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <i>Corsey Md.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Baltimore</i> Md.	
10. CITY OR TOWN OF DEATH <i>Catonsville Md.</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Forest Haven Nursing Home</i>	12a. USJA. OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>at Home</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Baltimore</i>	13c. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>1104 Washington Blvd.</i>
14. FATHER'S NAME First Middle Last <i>Unknown</i>	15. MOTHER'S MAIDEN NAME First Middle Last <i>Unknown</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>	16b. SOCIAL SECURITY NO <i>219-544201</i>	17. INFORMANT Address <i>Forest Haven Nursing Home 315 Gude Ave</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary Artery Disease</i>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that (I) (the hospital) attended the deceased from <i>3/12</i> , 19 <i>66</i> , to <i>2/2</i> , 19 <i>68</i> , that (I) (we) lost saw the deceased alive on <i>2/2</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <i>John H. Shaw, M.D.</i>		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <i>2/1/68</i>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <i>5800 Edmondson Ave Balt 38, Md.</i>		
23a. BURIAL, CREMATON, REMOVAL (Specify)	23b. DATE <i>2/5/68</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cem</i>	23d. LOCATION (City or Town) (County) (State) <i>2930 Frederick Ave Md.</i>	
24. FUNERAL DIRECTOR <i>John J. Bowman & Son Inc.</i>		25a. REC'D BY REGISTRAR <i>Hollins St.</i>	25b. REGISTRAR'S SIGNATURE <i>John J. Bowman & Son Inc.</i>	

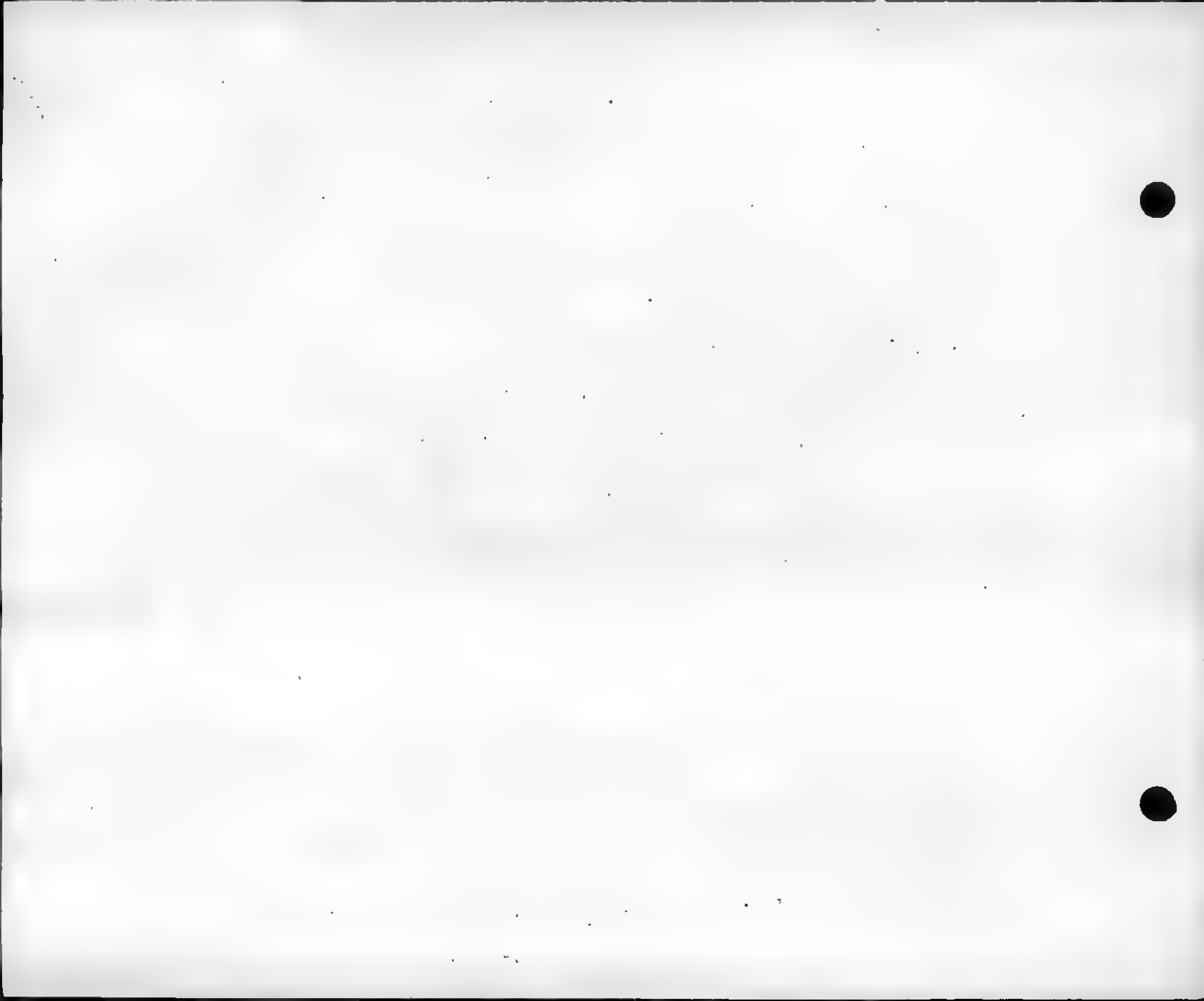


**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div>2176</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>165</div>																	
1. DECEASED NAME (Type or Print)			First			Middle			Last			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> FEB 25 1968			2b. HOUR 9:00 A.M.		
CHARLES L. FLANAGAN																	
3. SEX M		4. RACE W		5. DATE OF BIRTH 7/6/10		6. AGE (In years last birthday) 57 YRS		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS		7c. DATE PRONOUNCED DEAD FEB 25 1968		2d. HOUR 10:00 A.M.			
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH BALTO					
PA				USA								MD					
10. CITY OR TOWN OF DEATH ESSEX				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 128 WILTSHIRE				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) ENG.				12b. KIND OF BUSINESS OR INDUSTRY MARTINS					
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 128 WILTSHIRE			
MD				BALTO				ESSEX									
14. FATHER'S NAME						15. MOTHER'S M.A.D.E.N. NAME											
First						First						Middle					
CHARLES M. FLANAGAN						MAY HARKINS											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) UNK						16b. SOCIAL SECURITY NO (If yes give year or dates of service) 176-10-9670						17. INFORMANT HAZEL FLANAGAN					
												ADDRESS ABOVE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion																	
DUE TO, OR AS A CONSEQUENCE OF 4100																	
(Conditions if any which gave rise to immediate cause (a), stating the underlying cause lost.)																	
(b) Hypertensive C.V. Disease																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (At home, farm, street factory, office building, etc.)						21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
22b. DATE SIGNED 2/29/68																	
ACTUAL SIGNATURE EXAMINER'S NAME (Type)						M.B. DAVIS M.D. - DANIELS AND VIRN											
23a. BURIAL CREMATION REMOVAL (Specify)						23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
BURIAL						2/28/68		GARDENS OF FAITH				BALTO. MD.					
24. FUNERAL DIRECTOR						ADDRESS						25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE	
J.G. CONNELLY SONS						300 MACE						FEB 29 1968				Charles Judge	

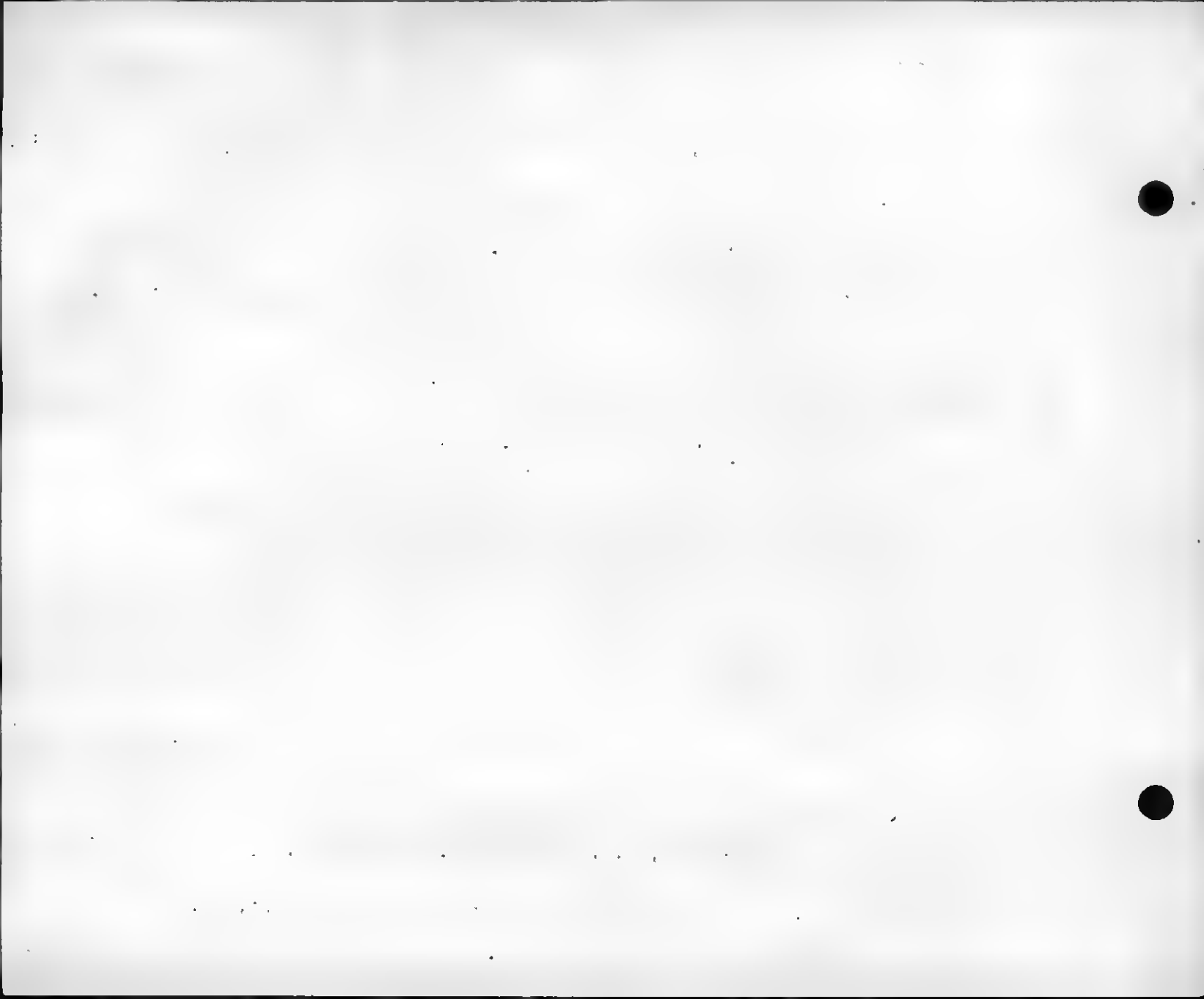


FOR STATE HEALTH DEPT.

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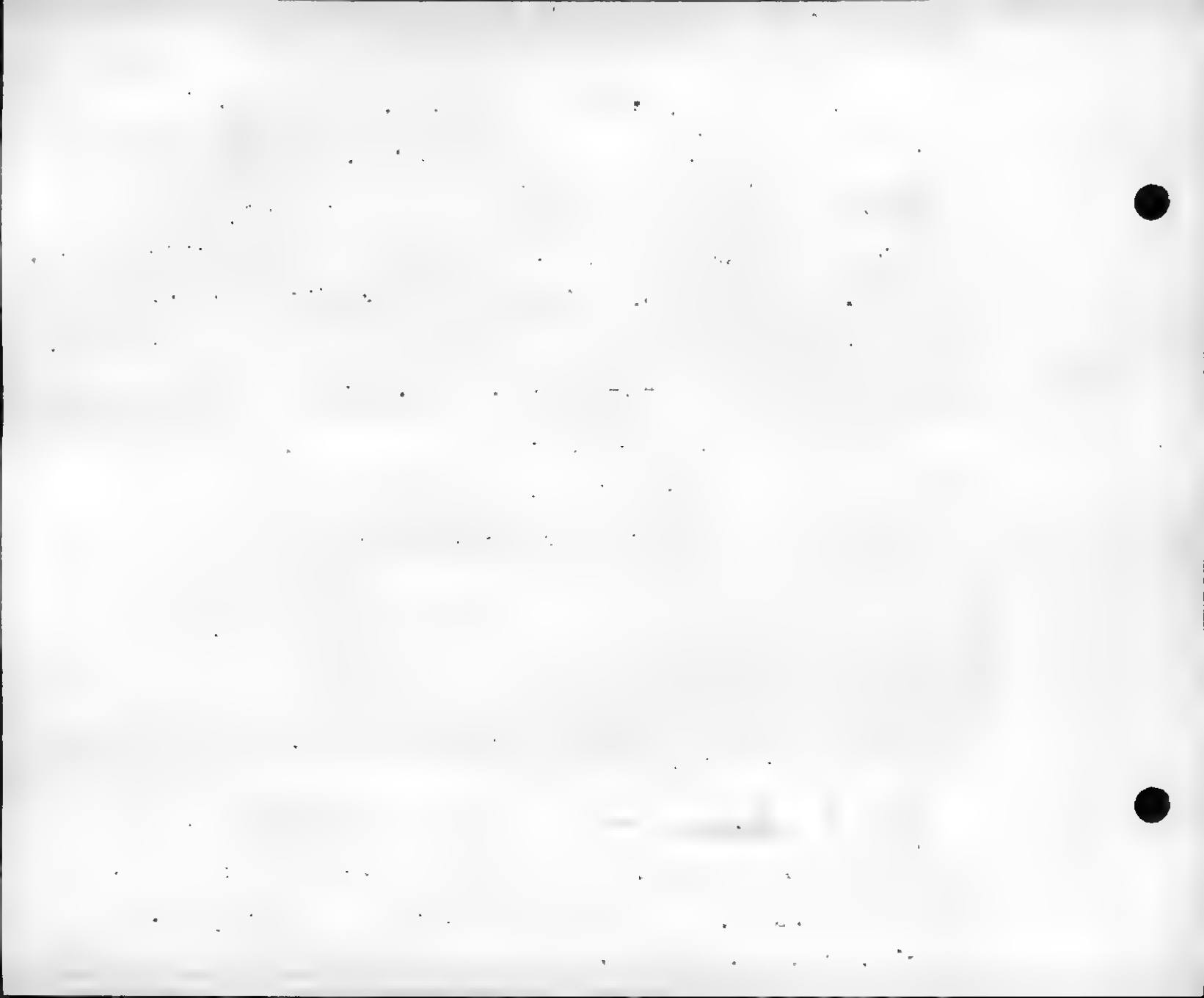
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or Print)			First JOHN			Middle FLEMING			Last			
3. SEX Male		4. RACE White		5. DATE OF BIRTH April 8, 1909		6. AGE (In years) 59 YRS		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Mass.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore			
10. CITY OR TOWN OF DEATH Oliver Peach (20)				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Box 160 Greenbank Rd.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Foreman			12b. KIND OF BUSINESS OR INDUSTRY Steel	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.				13b. COUNTY Baltimore		13c. CITY OR TOWN Oliver Peach		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Box 160 Greenbank Rd.		
14. FATHER'S NAME First John Middle Fleming Last						15. MOTHER'S MAIDEN NAME First Mary Middle Purdon Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16b. SOCIAL SECURITY NO (If yes give year or dates of service) 42-45		17. INFORMANT Evelyn Fleming		ADDRESS Same				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary occlusion</u>												
DUE TO, OR AS A CONSEQUENCE OF <u>ACVD</u>												
DUE TO, OR AS A CONSEQUENCE OF												
DUE TO, OR AS A CONSEQUENCE OF												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
22b. DATE SIGNED 2/17/68						22c. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22d. ACTUAL SIGNATURE Theodore Patterson, M.D. 105 Main St. Dundalk, Md.						22e. ADDRESS (Street, city, town or county)						
23a. BURIAL CREMATION, REMOVAL (Specify) Cremation				23b. DATE 2/19/68		23c. NAME OF CEMETERY OR CREMATORY Green Mount Crematory				23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR Bruzdzinski Funeral Home 1407 Eastern Ave.						25a. REC'D BY REGISTRAR DATE FEB 20 1968		25b. REGISTRAR'S SIGNATURE John J. [Signature]				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) LEWIS			First McDANIEL			Middle FORD, Sr.			Last		
2a. DATE OF DEATH 2 Month 7 Day 68 Year			2b. HOUR 11:25 A								
3 SEX Male			4. RACE Cau.			5. DATE OF BIRTH April 8, 1899.			6 AGE (n years) 68 YRS		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md		
10. CITY OR TOWN OF DEATH Balto., Maryland			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med. Center			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Supervisor Fisher Body Co.			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b. COUNTY Balto.			13c. CITY OR TOWN Timonium			3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME First William Middle Ford Last			15. MOTHER'S MAIDEN NAME First Lucy Middle Ford Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 216-09-8627			17. INFORMANT Mrs. Ruth A. Ford			Address (Same)		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hematopericardium											
DUE TO, OR AS A CONSEQUENCE OF (b) Rupture of heart											
DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial infarction and ASCVD											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 2/3 , 19 68 , to 2/7 , 19 68 , that (I) (we) last saw the deceased alive on 2/7 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John E. Adams			DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED Feb. 7, 1968					
22d. PHYSICIAN'S NAME (Type) John E. Adams, M.D.			22e. ADDRESS Greater Baltimore Medical Center								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 2/10/68.			23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park			23d. LOCATION (City or Town) (County) (State) Cambridge, Md.		
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214			ADDRESS			25a. REC'D BY REGISTRAR FEB 8 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		

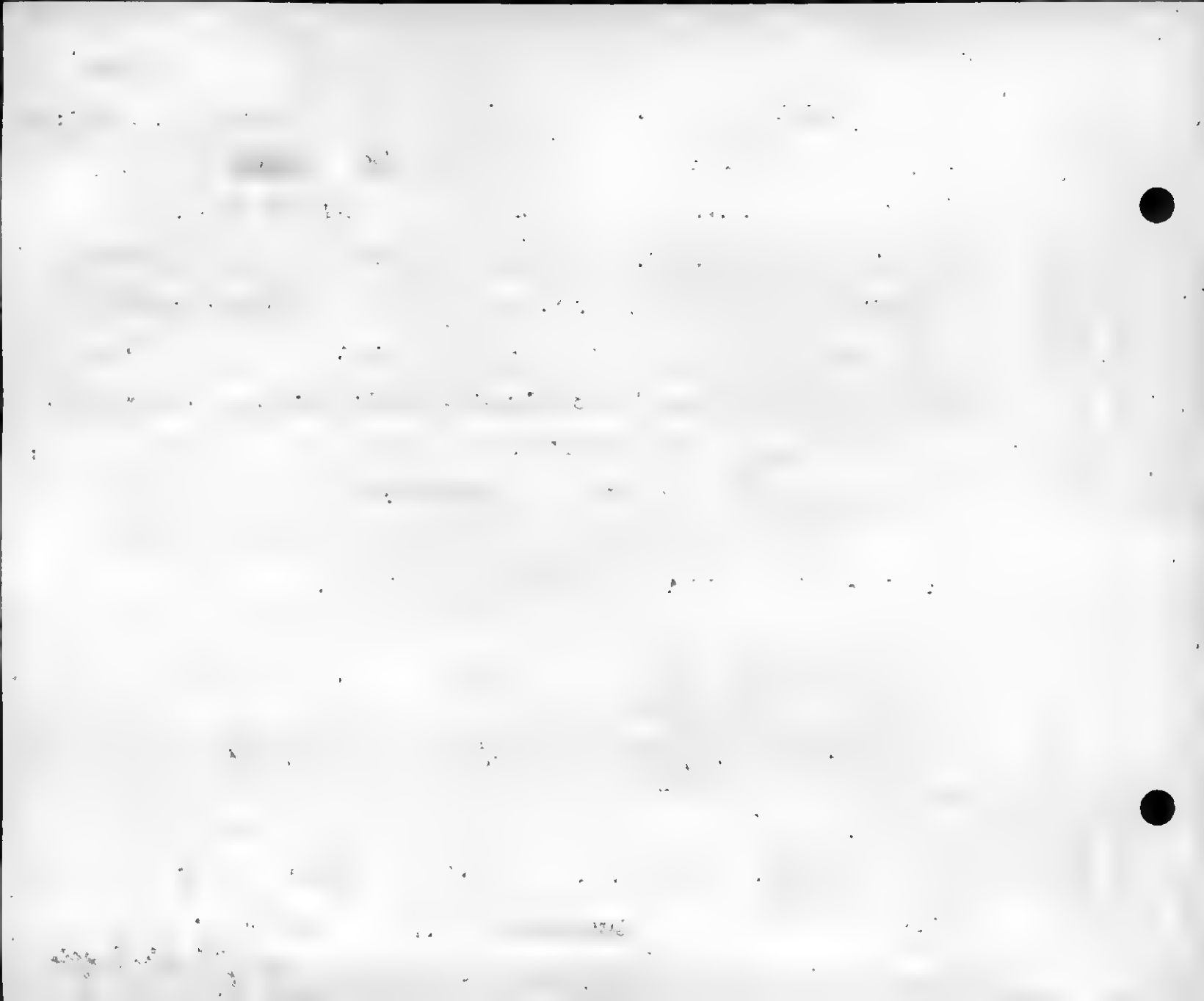


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2177
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 23b Film G398 2/28/68 kk
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) MELVIN WATTS FORTUNE			2a. DATE OF DEATH Month FEBRUARY Day 11 Year 1968			2b. HOUR 7:00PM	
3 SEX MALE		4. RACE NEGRO		5. DATE OF BIRTH 12/10/99		6. AGE (In years last birthday) 68 YRS.	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE COUNTY Md	
10. CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. ADM. HOSPITAL		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) JANITOR		12b. KIND OF BUSINESS OR INDUSTRY FACTORY	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1518 Retreat Street	
14. FATHER'S NAME First Kate Middle Rollins Last Fortune			15. MOTHER'S MAIDEN NAME First George Middle Fortune Last Fortune				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes		16b. SOCIAL SECURITY NO WW I 219 01 00 31		17. INFORMANT Address Clin. Records, VA Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE INTESTINAL OBSTRUCTION 5609 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 5702 (b) MESENTERIC ARTERY THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CHRONIC BRONCHITIS AND ARTERIOSCLEROTIC HEART DISEASE.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21a. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from 2/4/68 , 19__, to 2/11/68 , 19__, that (H) (we) lost the deceased alive on 2/11/68 , 19__, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John D. Talbert, M.D. DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED 2/12/68	
22d. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.		22e. ADDRESS VAH FORT HOWARD, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 2/15/68		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR KELSON FUNERAL HOME		25a. REC'D BY REGISTRAR DATE FEB 15 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



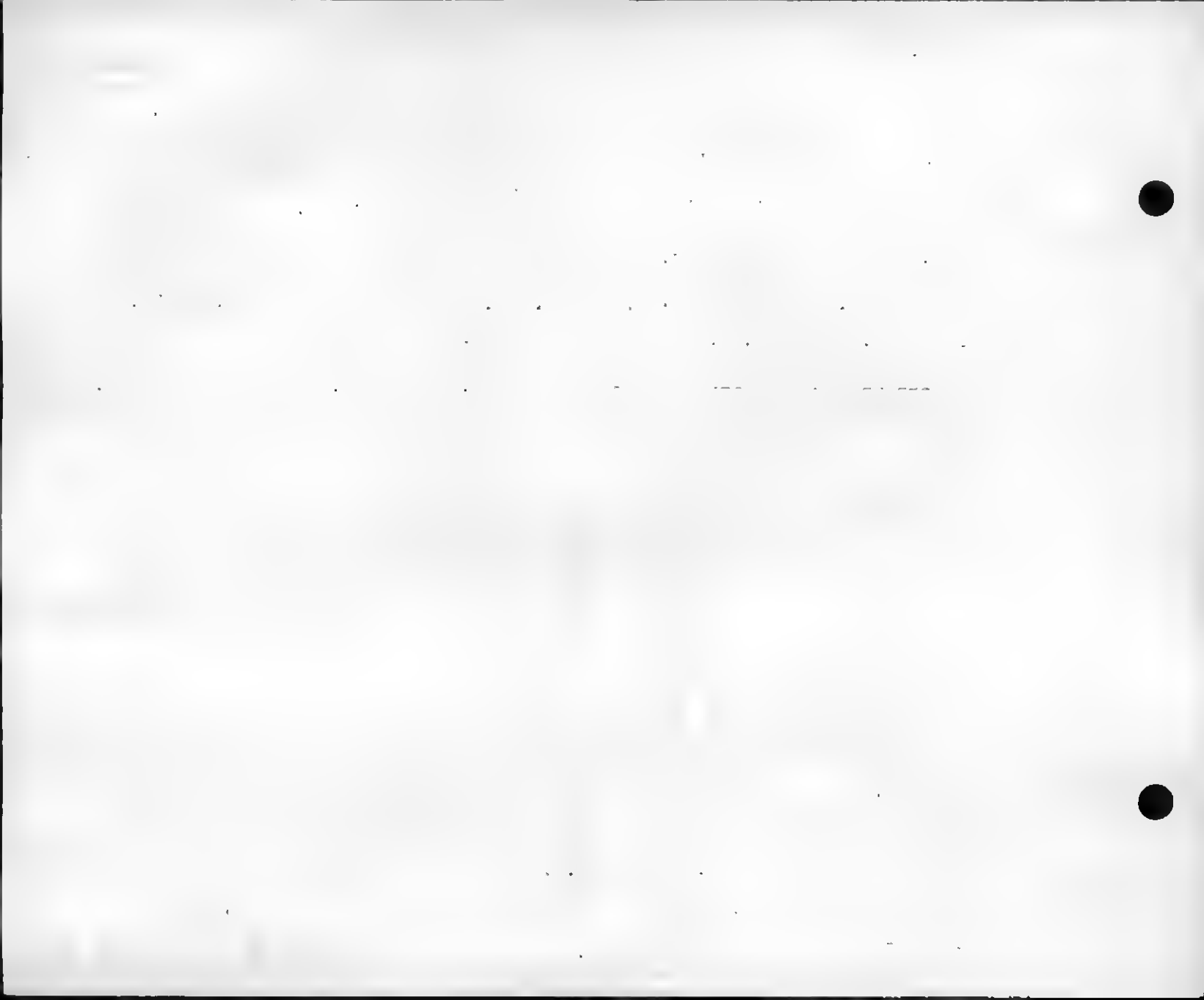
FOR STATE HEALTH DEPT.

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MEDICAL CERTIFICATION

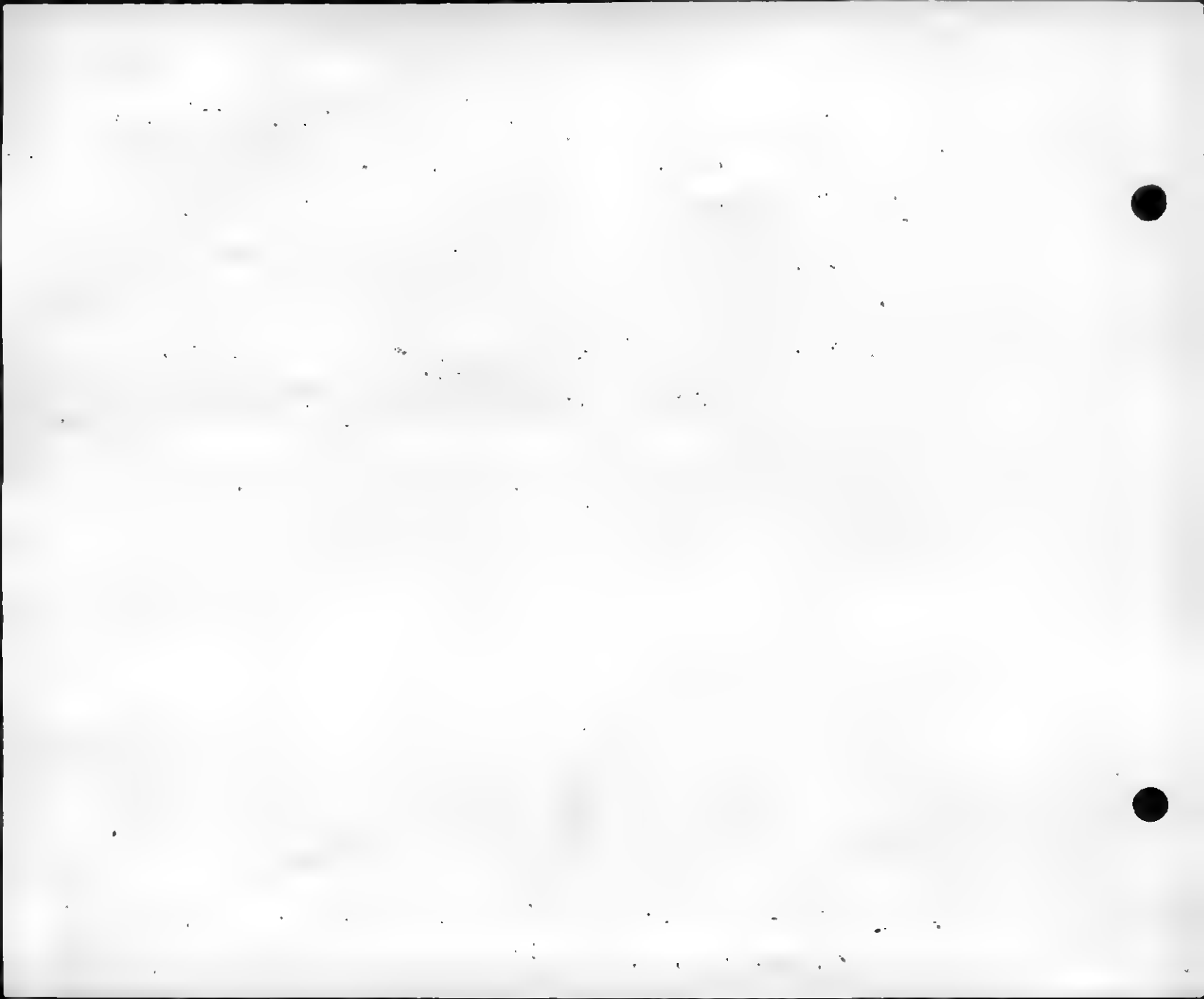
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or Print)			First MARGUERITE Middle WINTER Last FOSTER			2a DATE KNOWN OF DEATH Month Day Year		2b HOUR		
3 SEX Female			4 RACE White		5 DATE OF BIRTH July 3, 1896		6 AGE (in years) #37 1/2 YRS		7c DATE PRONOUNCED DEAD Month Day Year	
7b BIRTHPLACE (State or foreign country) Maryland			7b CITIZEN OF WHAT COUNTRY? U. S. A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Balto.		
10 CITY OR TOWN OF DEATH Balto.			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) St. Joseph Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) Housewife		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Md.			13b COUNTY Balto.		13c CITY OR TOWN Balto.		13d INSIDE CITY - MAP? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 500 Dunkirk Rd.	
14 FATHER'S NAME First Middle Last William T. Tippettt, Sr.					15 MOTHER'S M A D E N NAME First Middle Last E. Edna Freeman					
16a WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16b SOCIAL SECURITY NO 217-12-0910		17 INFORMANT John H. Winter, Jr. 1503 Maywood Ave. 21204					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> 486X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 493X										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or RFD No City or Town County State					
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect on <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Edward F. Wilson, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED February 14, 1968			
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE Feb. 16, 1968		23c NAME OF CEMETERY OR CREMATORY Greenmount Crematory		23d LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24 FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson, Md. 21204					25b REC'D BY REG STRAR DATE Feb 16 1968		25a REG STRAR'S SIGNATURE Charles Jones			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH																																			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																																			
CERTIFICATE OF DEATH																																			
1 DECEASED NAME (Type or print)			First MARY			Middle ANN			Last FOSTER			2a. DATE OF DEATH			Month February			Day 5			Year 1968			2b. HOUR			M								
3 SEX			FEMALE			4 RACE			CAU			5 DATE OF BIRTH			7-7-87			6 AGE (In years last birthday)			80			7 UNDER 1 YEAR			IF UNDER 24 HRS								
7a BIRTHPLACE (State or foreign country)			CARROLL Co MD			7b CITIZEN OF WHAT COUNTRY?			USA			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH									BALTIMORE			Md								
10 CITY OR TOWN OF DEATH						11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)						12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)						12b KIND OF BUSINESS OR INDUSTRY																	
BALTO COUNTY						G B M C						HOUSE-WIFE																							
13a USUA. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE						13b COUNTY						13c CITY OR TOWN						13d INSIDE CITY LIM TSP						13e STREET AND NUMBER											
MD						CARROLL												YES <input type="checkbox"/> NO <input type="checkbox"/>						3814 OAK AVE											
14. FATHER'S NAME						First Middle Last						15 MOTHER'S MAIDEN NAME						First Middle Last																	
UNKNOWN						Gunter						UNKNOWN						Giggard																	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)						(If yes give war or dates of service)						16b SOCIAL SECURITY NO						17. INFORMANT						Address											
												216-05-6969						JOHN L. HUSBAND						3814 OAK AV Zone 7											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																							
PART I. DEATH WAS CAUSED BY:																																			
IMMEDIATE CAUSE (a)												Pneumonia																							
47°C. x																																			
DUE TO, OR AS A CONSEQUENCE OF																																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												(b) Impetive failure																							
DUE TO, OR AS A CONSEQUENCE OF																																			
(c)																																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																			
4-7																																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?						20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																	
												YES <input type="checkbox"/> NO <input type="checkbox"/>																							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)						21b. TIME OF INJURY						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																							
						HOUR A.M. Month Day Year P.M. 19																													
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>						21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)						21f LOCATION Street or R.F.D. No. City or Town County State																							
22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																			
22b SIGNATURE												22c DATE SIGNED																							
M.G. Lawrence												2/7/68																							
22d PHYSICIAN'S NAME (Type)												22e ADDRESS																							
												G B M C.																							
23a BURIAL, CREMATION, REMOVAL (Specify)						23b DATE						23c NAME OF CEMETERY OR CREMATORY						23d LOCATION (City or Town) (County) (State)																	
BURIAL						2-9-68						Leister's Cemetery						CARROLL Co, MARYLAND																	
24 FUNERAL DIRECTOR												25a. REC'D BY REGISTRAR												25b REGISTRAR'S SIGNATURE											
EIKWORTH ARMACOST-4600 Liberty Hgts												DATE												6 1968											



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VR A15 (4)
25M 1/67

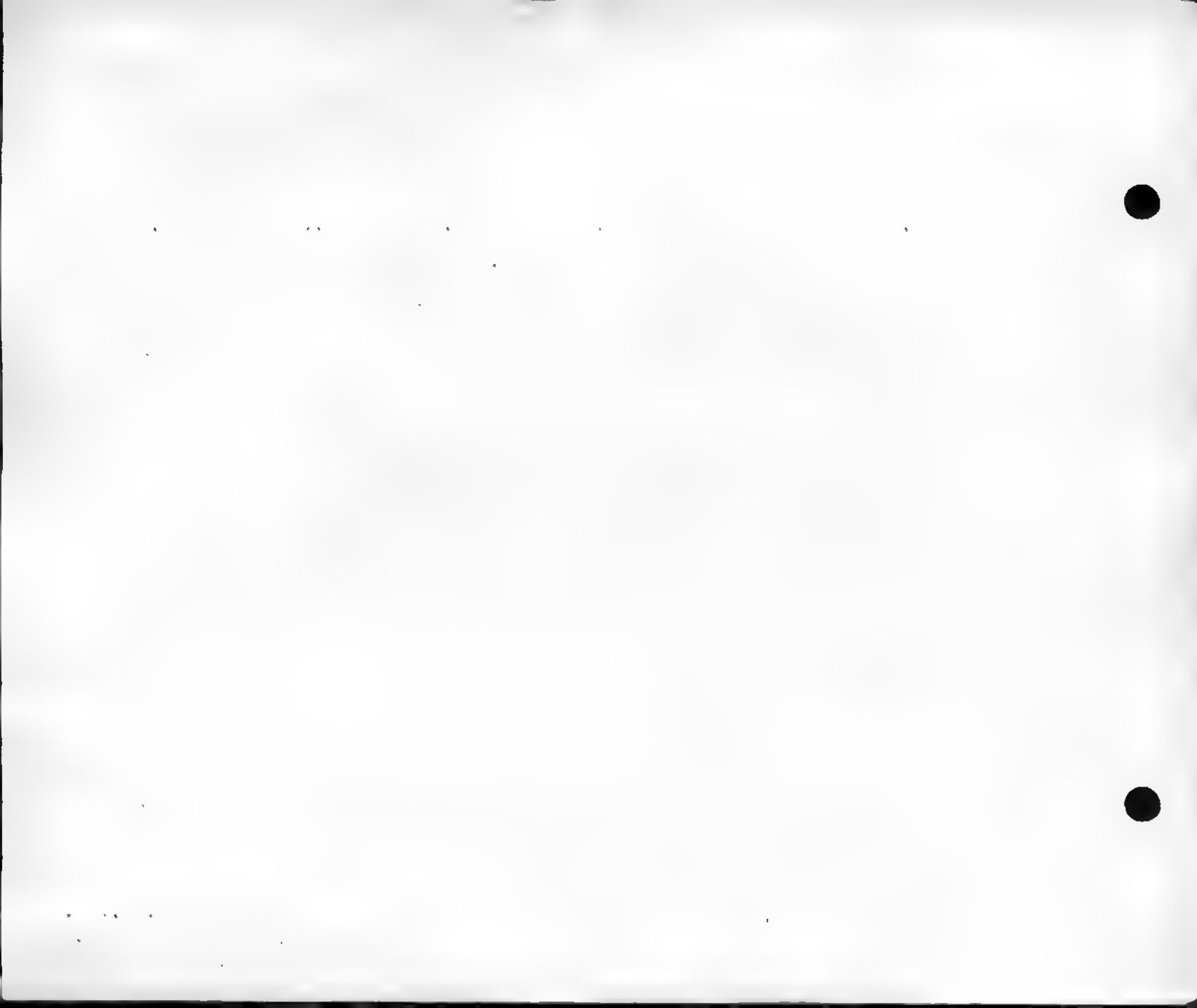
02182

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02171

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hereford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hereford</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Carmel Road near York Rd.</u>		d. STREET ADDRESS <u>St. Carmel Rd., near York Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>John F. Fowble, Sr.</u>		4. DATE OF DEATH Month <u>February</u> Day <u>14</u> Year <u>1968</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 11, 1881</u>
9 AGE (In years last birthday) <u>86</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Mins. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer-retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sol. employed</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Fowble</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Toney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>218-05-6018</u>	
17. INFORMANT <u>Family records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>C.L.S. C.V. disease</u> <u>4127</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4127</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 14, 1968</u> to <u>Feb 14, 1968</u> , that (I) (we) last saw the deceased alive on <u>2/14</u> 19 <u>68</u> , and that death occurred at <u>4P</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>A. M. France</u> M.D.		22b. DATE SIGNED <u>2/15/68</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>		22d. ADDRESS <u>Parkton Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Feb. 17, 1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Grove Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hereford, Balto. Co., Md.</u>
24. FUNERAL DIRECTOR <u>John Wynn's Sons, Towson, Md</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 20 1968</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO PUBLIC HEALTH DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cover papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 2 Film G390 3/1/68 KK

CERTIFICATE OF DEATH

2172

1 PLACE OF DEATH a. COUNTY Baltimore Maryland		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore. Pikesville, Md.		c LENGTH OF STAY IN 1b Baltimore. Pikesville, Md.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Milford Manor Nursing Home		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bessie		4. DATE OF DEATH Last Feb Month 2 Day 26 Year 1968	
5 SEX F	6 COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1893
9 AGE (In years last birthday) 75 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11 BIRTHPLACE (County & State or foreign country) Russia		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Paseach Mizrach		14. MOTHER'S MAIDEN NAME Gittel	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16 SOCIAL SECURITY NO no	
17 INFORMANT Mr. Jerome Feld 3715 Clarinthe Rd.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) Arteriosclerosis DUE TO (c) last		INTERVAL BETWEEN ONSET AND DEATH 7 hrs	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Feb. 26 , 19 68 , to Feb 26 , 19 68 , that (I) (we) last saw the deceased alive on Feb 22 , 19 68 , and that death occurred at 3:00 AM , from causes and on the date stated above.			
22a SIGNATURE David J. Miller M.D.		22b DATE SIGNED 7 Feb 68	
22c PHYSICIAN'S NAME (Type) David J. Miller		22d ADDRESS Union R. Co. Englewood, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF Feb. 26th. 1968	
23c NAME OF CEMETERY OR CREMATORY Shomrei Hadath Cem.		23d LOCATION (City or town) (County) (State) Rosedale, Baltimore, Md.	
24 FUNERAL DIRECTOR Sylvan S. Lewis & Son		25a REC'D BY REGISTRAR Feb 28 1968	
ADDRESS P.O. Box 65 Harrison, Md.		25b REGISTRAR'S SIGNATURE Charles Judge	



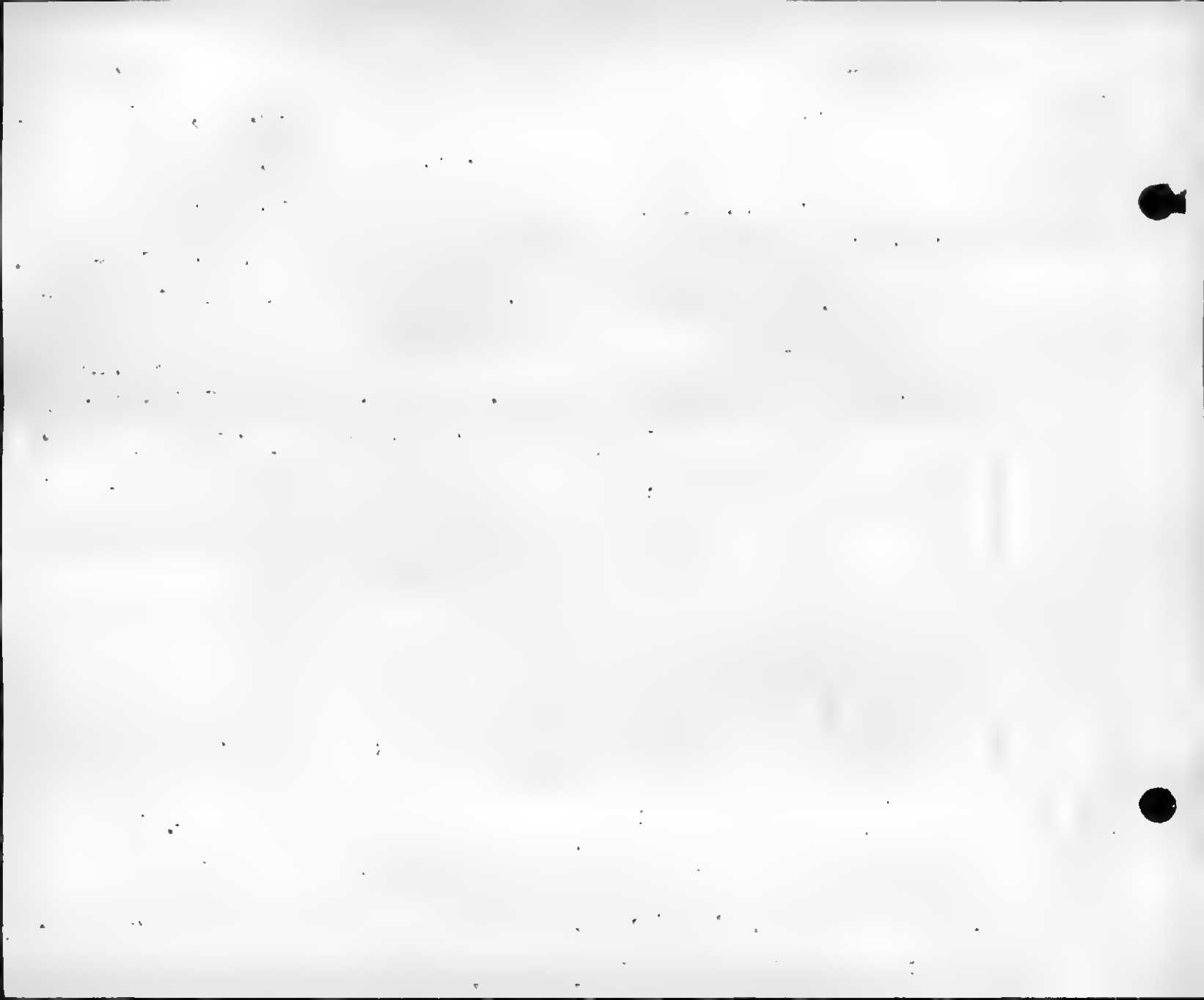
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled up by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Arthur Lee France			2a. DATE OF DEATH Month Feb. Day 11 Year 1968			2b. HOUR 6 P.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH Jan. 11, 1881		6. AGE (In years last birthday) 87 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County Md			
10. CITY OR TOWN OF DEATH Catonsville Baltimore City		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Home Ridgely Manor Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Glass Blower		12b. KIND OF BUSINESS OR INDUSTRY Self-Empl.			
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 415 Rosecroft Terrace	
14. FATHER'S NAME First Middle Last Thomas France				15. MOTHER'S MAIDEN NAME First Middle Last Sarah Shipley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO 086-05-9696		17. INFORMANT Mrs. Helen M. Berbus - Balto. Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized Calcivomyelitis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Calcivomyelitis Prostate DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 YR + 2 YRS +									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from JANUARY 1967 to FEB. 11, 1968 , that (I) (we) last saw the deceased alive on 2/10 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Thomas E. Roach				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2/12/68			
22d. PHYSICIAN'S NAME (Type) 5550 B220 NARR PKE				22e. ADDRESS THOS E ROACH					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 2/13/68		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore - AA County - Md.			
24. FUNERAL DIRECTOR Sterling Funeral Estate - 736 Edmondson Ave. - Catonsville				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			

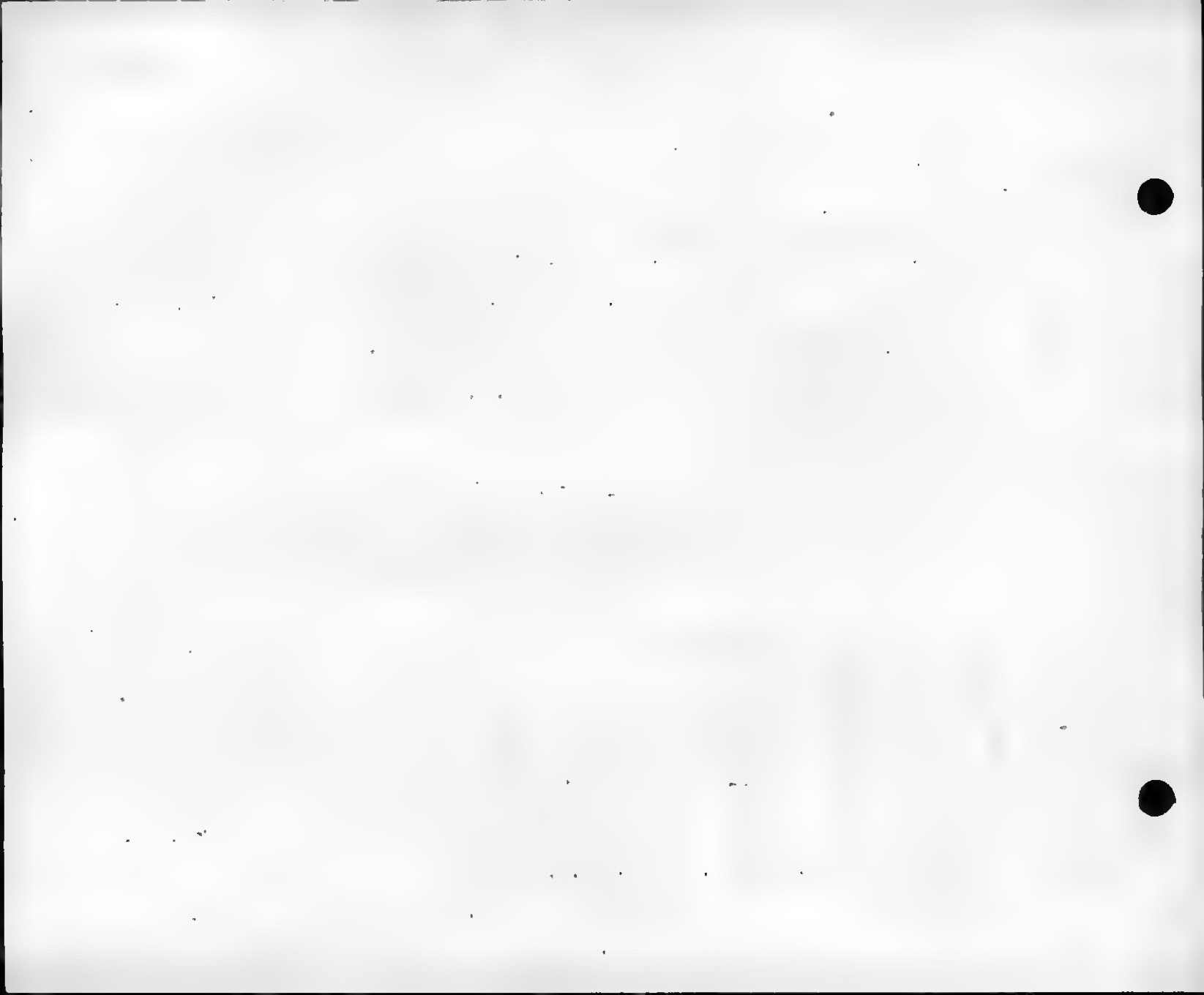


FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or Print)		First		Middle		Last		20. DATE KNOWN OF ESTI DEATH MATED		Month	Day	Year	2b. HOUR				
CRYSTAL FRAZIER								2. 23		19	68	10:45					
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (last birthday)	7 UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		Month	Day	Year	2a. HOUR			
Female	White	Oct 21/21		46 YRS					February		23	19	68	10:45			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9. COUNTY OF DEATH									
Md		U.S.		WIDOWED		DIVORCED		Balto.						Md			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY					
Balto.				St. Joseph Hospital				Checker				A & P Store					
13a. USUAL RESIDENCE (Where deceased lived if institution admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER							
Md				Balto.		Balto.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8824 Victory Ave.							
14 FATHER'S NAME				First		Middle		Last		15 MOTHER'S MAIDEN NAME		First		Middle		Last	
Elmer Bowen										Ethel M. Wink							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO		17 INFORMANT		ADDRESS									
no				no		?		Wm.F. Frazier, Sr.		8824 Victory Ave							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Peritonitis</u>																	
DUE TO, OR AS A CONSEQUENCE OF																	
(Condition if any, which gave rise to immediate cause (a), stating the underlying cause lost.)																	
(b) <u>Perforation of duodenal ulcer</u>																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
5411																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?									
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING				21b. TIME OF INJURY Month, Day Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)									
<input type="checkbox"/>				HOUR A.M. P.M. 19													
21d. INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State									
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>																	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED									
Edward F. Wilson				<input type="checkbox"/>				Feb. 23, 1968									
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER				<input checked="" type="checkbox"/>									
Edward F. Wilson, M.D.				DEPUTY MEDICAL EXAMINER				<input type="checkbox"/>									
				ADDRESS (Street, city, town, or county)													
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)									
Burial				Feb 26, 1968		Moreland Memorial		Taylor Ave, Md									
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Austin E. Donovan				3818 Roland Ave				FEB 26 1968		[Signature]							

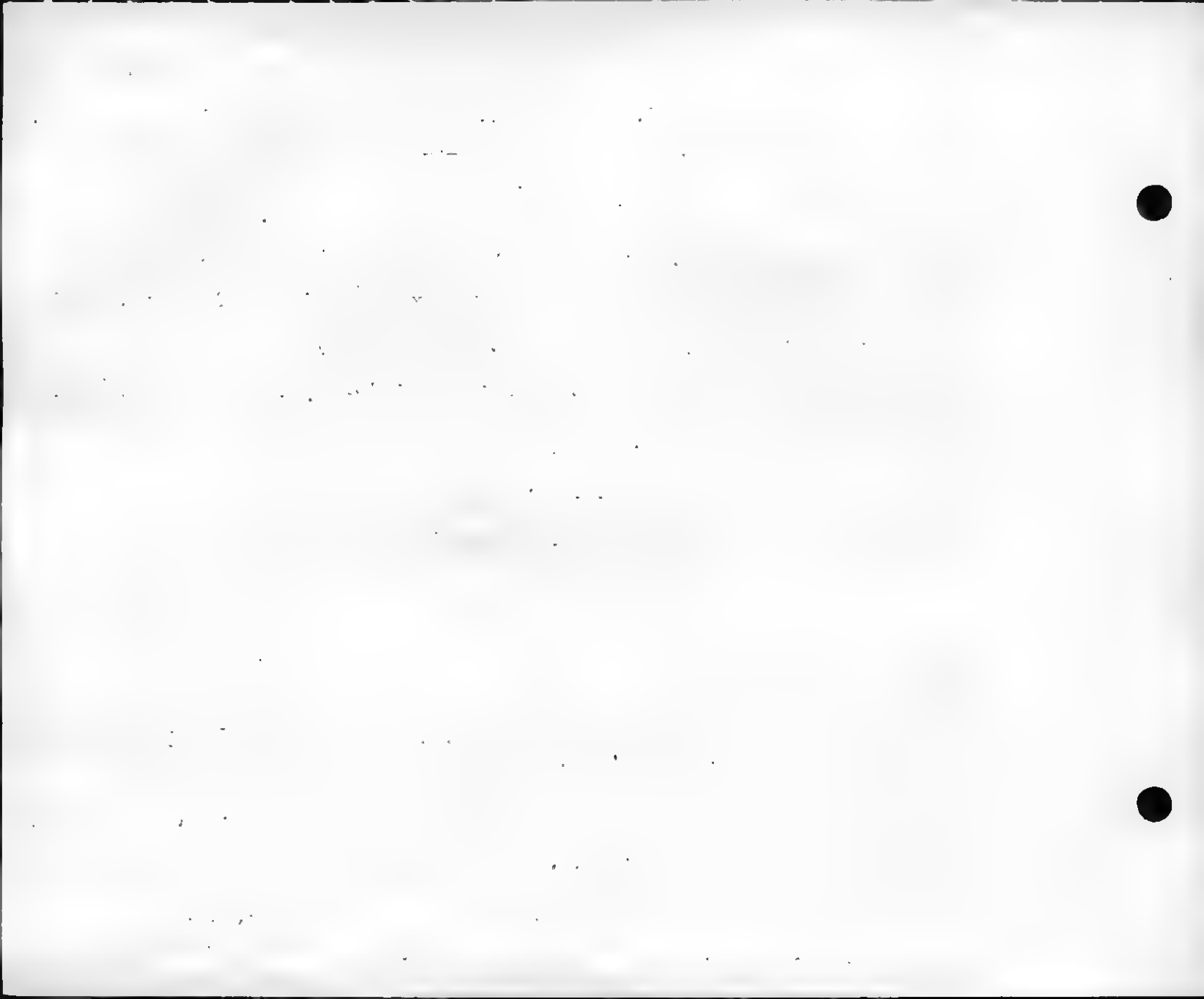


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

32186										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										02175																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First Middle Last Francis C. FREDERICK										Month Day Year February 18 68										10pm M																																							
3 SEX Male										4 RACE white										5. DATE OF BIRTH 8-6-01										6 AGE (In years last birthday) 66										7 UNDER 1 YEAR MONTHS DAYS										8 UNDER 24 HRS HOURS MIN.									
7a BIRTHPLACE (State or foreign country) Pennsylvania										7b CITIZEN OF WHAT COUNTRY? USA										8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9 COUNTY OF DEATH Balto. Md																													
10 CITY OR TOWN OF DEATH Towson										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Josephs Hospital										12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) MAINTENANCE										12b KIND OF BUSINESS OR INDUSTRY AUTO																													
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland										13b COUNTY BALTO										13c CITY OR TOWN Baltimore										13d INSIDE CITY LIM YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e STREET AND NUMBER 708 Maryland Ave. 21221																			
14. FATHER'S NAME First Middle Last HENRY B. FREDERICK										15 MOTHER'S MAIDEN NAME First Middle Last ANN REIMAN										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) UNK										16b. SOCIAL SECURITY NO. 216-03-0627										17. INFORMANT MARY FREDERICK										Address ABOVE									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4107</u> Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary arteriosclerosis</u>										BETWEEN ONSET AND DEATH																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																											
19a DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from January 26, 1968, to February 1968, that (I) (we) last saw the deceased alive on February 18, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE [Signature] DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>										22c. DATE SIGNED February 19, 1968																																							
22d. PHYSICIAN'S NAME (Type) Lawrence F. Misanik, M.D.										22e. ADDRESS 7620 York Rd., Towson, Md. 21204																																																	
23a BURIAL, CREMATION, REMOVAL (Specify) REMOVAL										23b DATE 2/22/68										23c. NAME OF CEMETERY OR CREMATORY WOODLAWN CEM										23d LOCATION (City or Town) (County) (State) ALLENTOWN PA																													
24. FUNERAL DIRECTOR J.G. CONNELLY SONS										ADDRESS 300 MACE										25a REC'D BY REGISTRAR DATE FEB 21 1968										25b REGISTRAR'S SIGNATURE [Signature]																													

MEDICAL CERTIFICATION

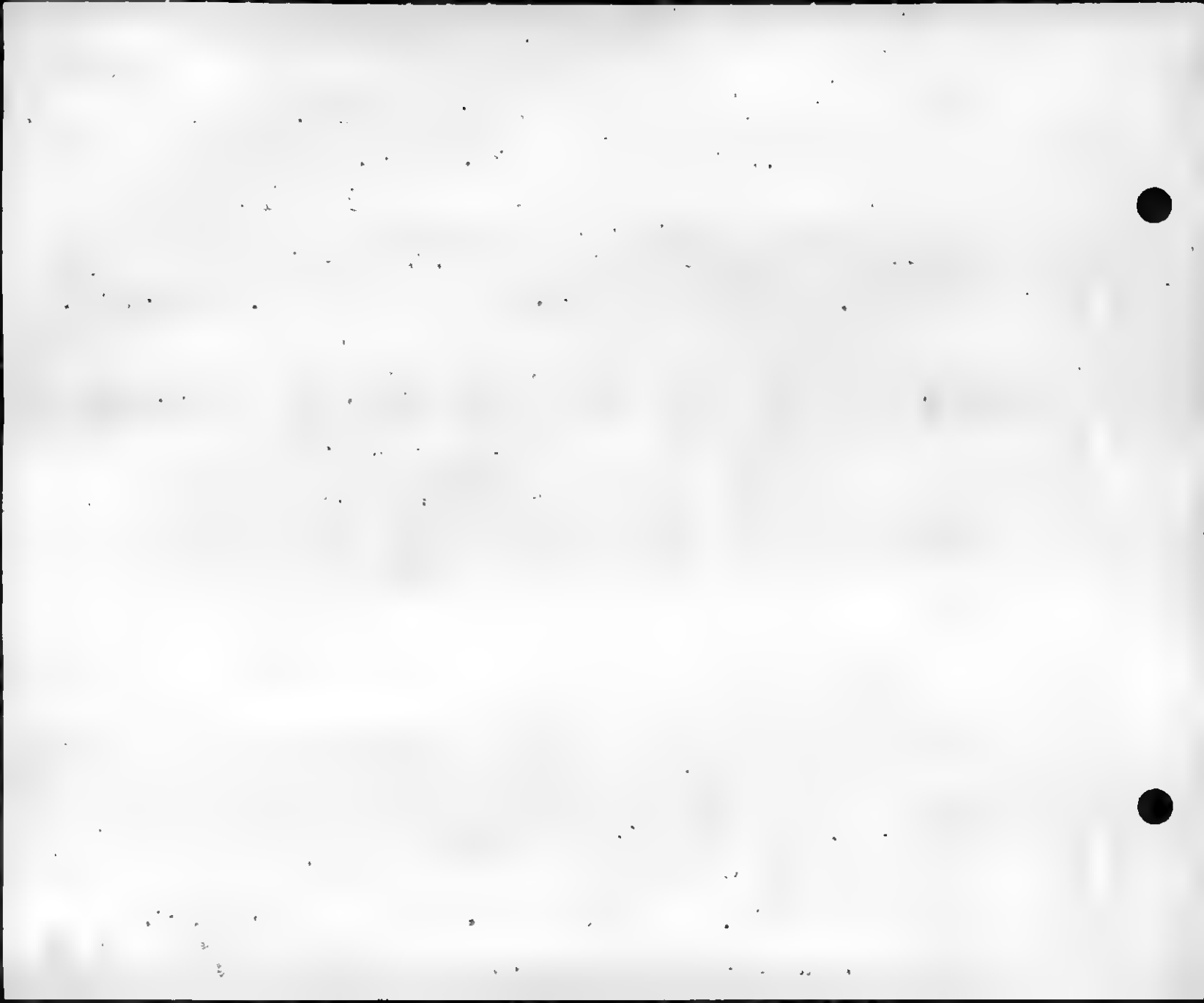


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02175

1. DECEASED NAME (Type or print) <i>Elizabeth</i>		First <i>Elizabeth</i>		Middle		Last <i>Fuchs</i>		2a. DATE OF DEATH Month <i>Feb.</i> Day <i>13</i> Year <i>1968</i>		2b. HOUR <i>6 P.M.</i>	
3 SEX <i>female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>Dec. 6, 1875.</i>				6. AGE (In years last birthday) <i>92</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i>					
10. CITY OR TOWN OF DEATH <i>Catonsville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>House In the Pines N.H.</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>USA</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY L.M.T.S? <i>YES</i> <input checked="" type="checkbox"/> <i>NO</i> <input type="checkbox"/>		13e. STREET AND NUMBER <i>939 N. Collington Ave.</i>			
14. FATHER'S NAME First <i>George</i> Middle <i>Giel</i> Last <i>Giel</i>				15. MOTHER'S MAIDEN NAME First <i>Unknown</i> Middle <i></i> Last <i></i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT Address <i>Carroll Fuchs, 8805 Alnwick Rd. 21234</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Ischemia</i> <i>4-11</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 mo.</i> <i>10 yr</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>8-5-1967</i> , to <i>2-13-1968</i> , that (I) (we) last saw the deceased alive on <i>2-12-1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Wilmer K. Gallagher, M.D.</i> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>								22c. DATE SIGNED <i>2-13-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Wilmer K. Gallagher</i>								22e. ADDRESS <i>62097 Edwicks Ave, Balt., Md. 21228</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>2/17/68.</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Md.</i>					
24. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc Baltimore, Md.</i>				ADDRESS		25a. RECD BY REGISTRAR DATE <i>FEB 15 1968</i>		25b. REG. STAMP SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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Page 4 may be retained by the hospital or attending physician.

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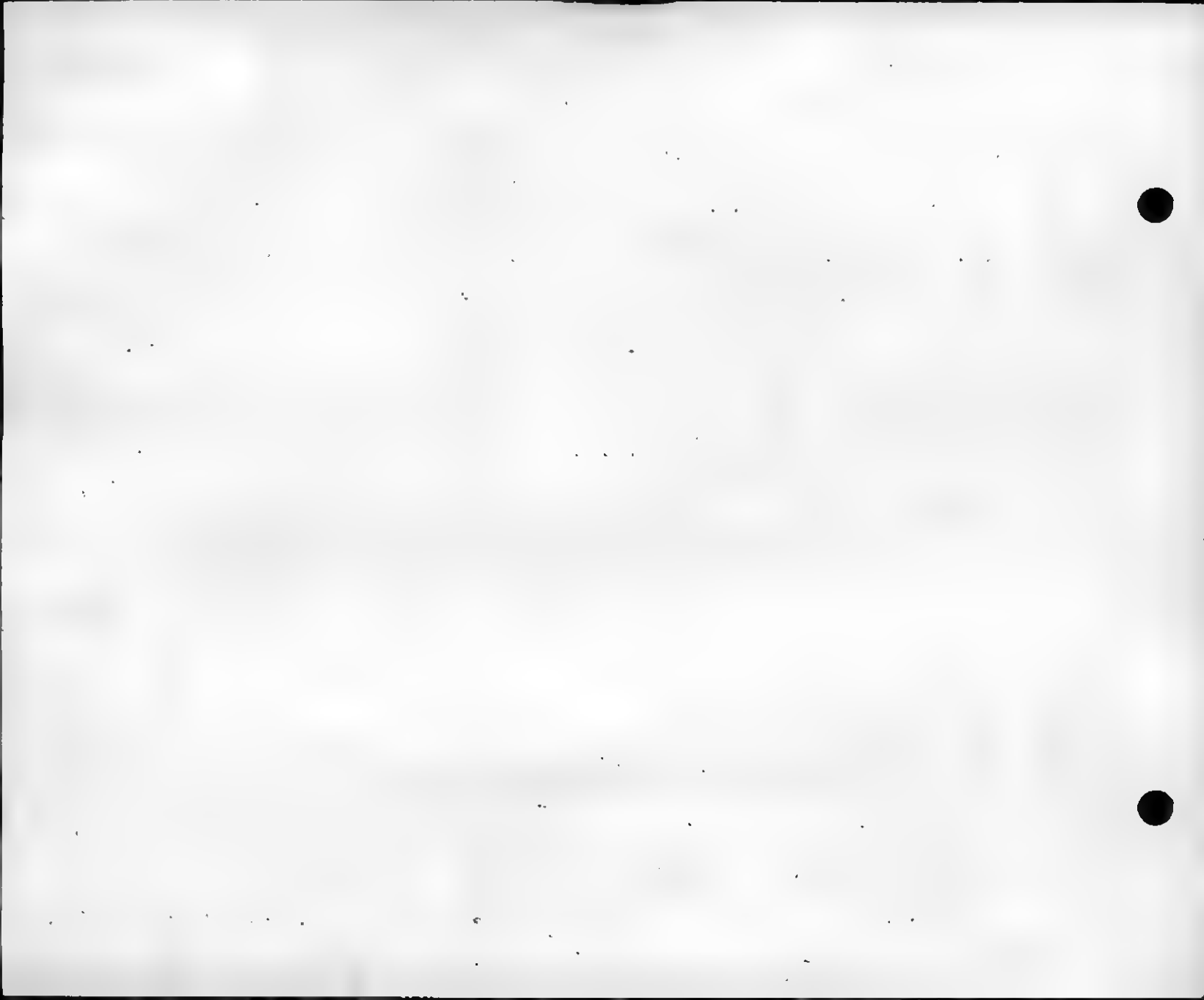
VR A15 (4)
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First Mary	Middle L.	Last Gambrill	2a. DATE OF DEATH Feb. Month 2 Day 68 Year		2b. HOUR M	
3 SEX Female		4 RACE White		5. DATE OF BIRTH March 12, 1909		6 AGE (In years last birthday) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Co. Md		
10. CITY OR TOWN OF DEATH Mt. Washington		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6719 Broadview Rd		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution on Res dence before admission) STATE Md.		13b. COUNTY Balto Co.		13c. CITY OR TOWN Mt. Washington		13d. INS. DE CITY - MORTIS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 6719 Broadview Rd. 21209
14. FATHER'S NAME		First August	Middle Flemming	Last Hammel		15. MOTHER'S MA DEN NAME First Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <input checked="" type="checkbox"/> No		16b. SOCIAL SECURITY NO ---		17. INFORMANT Mr. George C. Gambrill 6719 Broadview Rd. (9)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of breast</u> <u>1621</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u> <u>april 66</u>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>1966</u> , 19 <u>1966</u> , to <u>1968</u> , 19 <u>1968</u> , that (I) (we) last saw the deceased alive on <u>2-1-68</u> 19 <u>1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Harold J. Burns MD</u>				22c. DATE SIGNED <u>2-2-1968</u>		22d. ADDRESS <u>8106 Harford Road</u>		
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE <u>2-5-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Butler Methodist Church</u>		23d. LOCATION (City or Town) (County) (State) <u>Butler Balto Co Md</u>		
24. FUNERAL DIRECTOR <u>Frank A. Leitch</u>		ADDRESS <u>814 W 36 St Balto</u>		25a. REC'D BY REGISTRAR <u>FEB 5 1968</u>		25b. REGISTRAR'S SIGNATURE <u>William J. Judge</u>		

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

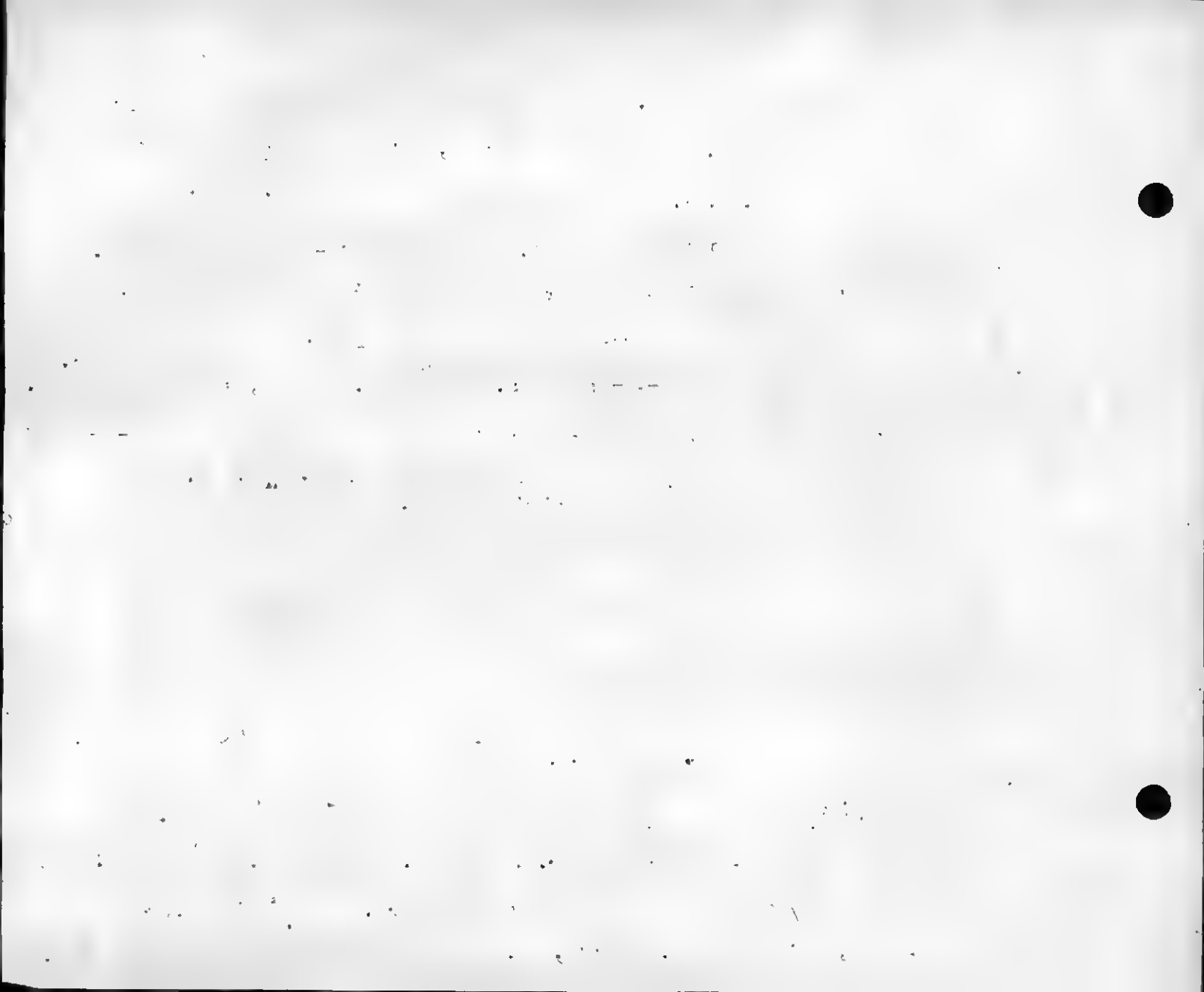
CERTIFICATE OF DEATH

02176

1 DECEASED NAME (Type or print) Milford			First C.			Middle Garrett			Last			2a. DATE OF DEATH Month February Day 20 Year 1968			2b. HOUR M		
3. SEX Male			4 RACE White			5 DATE OF BIRTH July 8, 1910			6 AGE (In years last birthday) 57 YRS			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Baltimore								
10 CITY OR TOWN OF DEATH Dundalk			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 8141 Parkhaven Rd.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Foreman-Bethlehem Steel Co.			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Dundalk			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 8141 Parkhaven Rd.					
14 FATHER'S NAME Archie			First Garrett			Middle			Last			15 MOTHER'S MAIDEN NAME Margaret			First Schlaile		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No (If yes, give war or dates of service)			16b. SOCIAL SECURITY NO 213-07-4579			17 INFORMANT (Wife) Mrs. Margaret F. Garrett,			Address Dundalk, Md.								
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchial pneumonia 16001 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastasis squamous cell ca of unknown origin (poss. lung) DUE TO, OR AS A CONSEQUENCE OF (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3- days		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (1) (this hospital) attended the deceased from 11-15, 1967 to 2-20, 1968 , that (1) (we) lost saw the deceased alive on 2-10-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Charles E. Thompson			22c. DATE SIGNED 2/20/68			22d. PHYSICIAN'S NAME (Type) Charles E. Thompson			22e. ADDRESS M.D. 2903 W. Woodwell Rd. Dundalk, Md. 21222								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 2/23/68			23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus Cem.			23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland								
24. FUNERAL DIRECTOR John J. Duda,			ADDRESS 7922 Wise Ave. Dundalk, Md.			25a. REC'D BY REGISTRAR DATE FEB 26 1968			25b. REGISTRAR'S SIGNATURE Charles Judge								

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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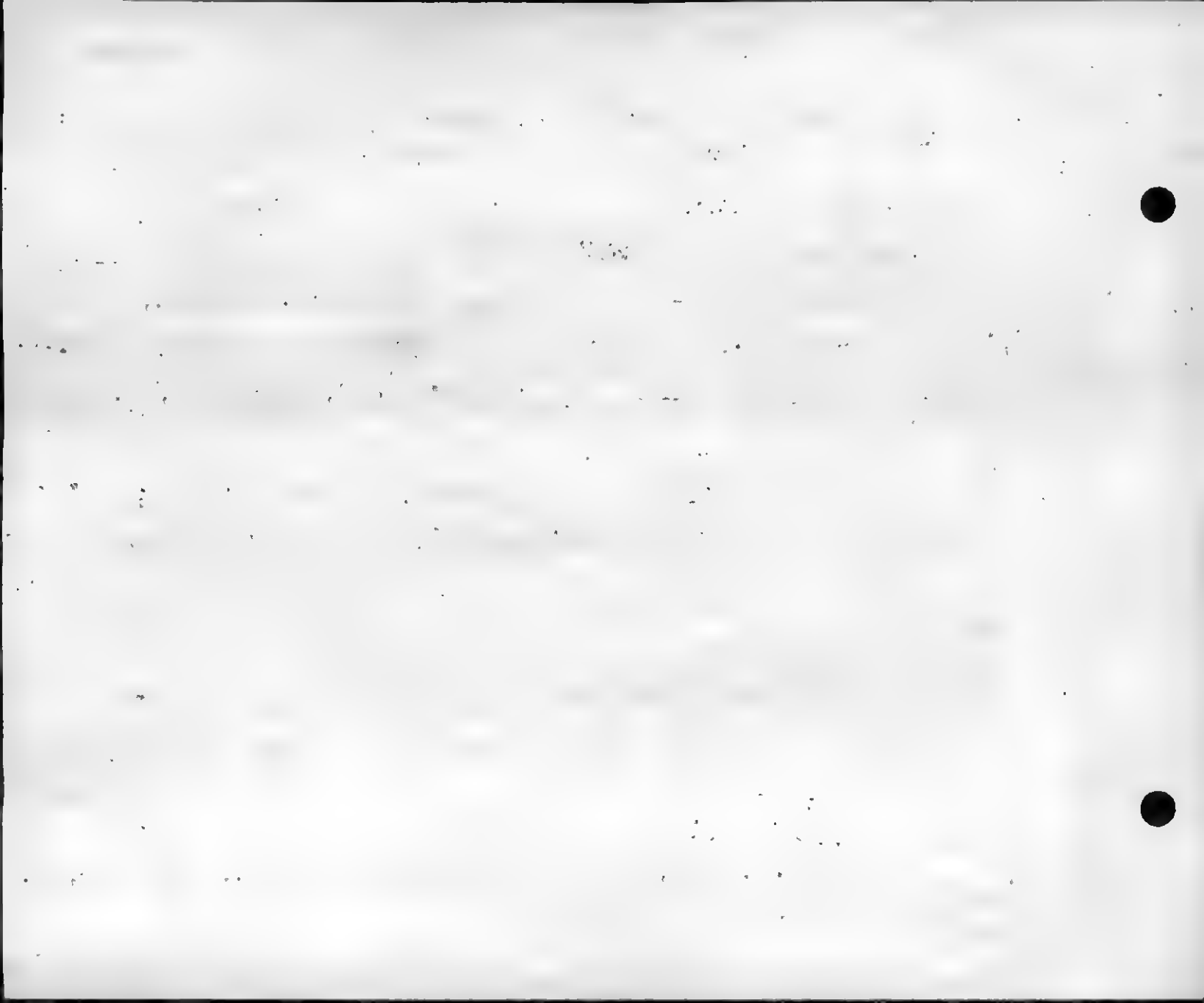


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VR 1554
30M REV 1-78

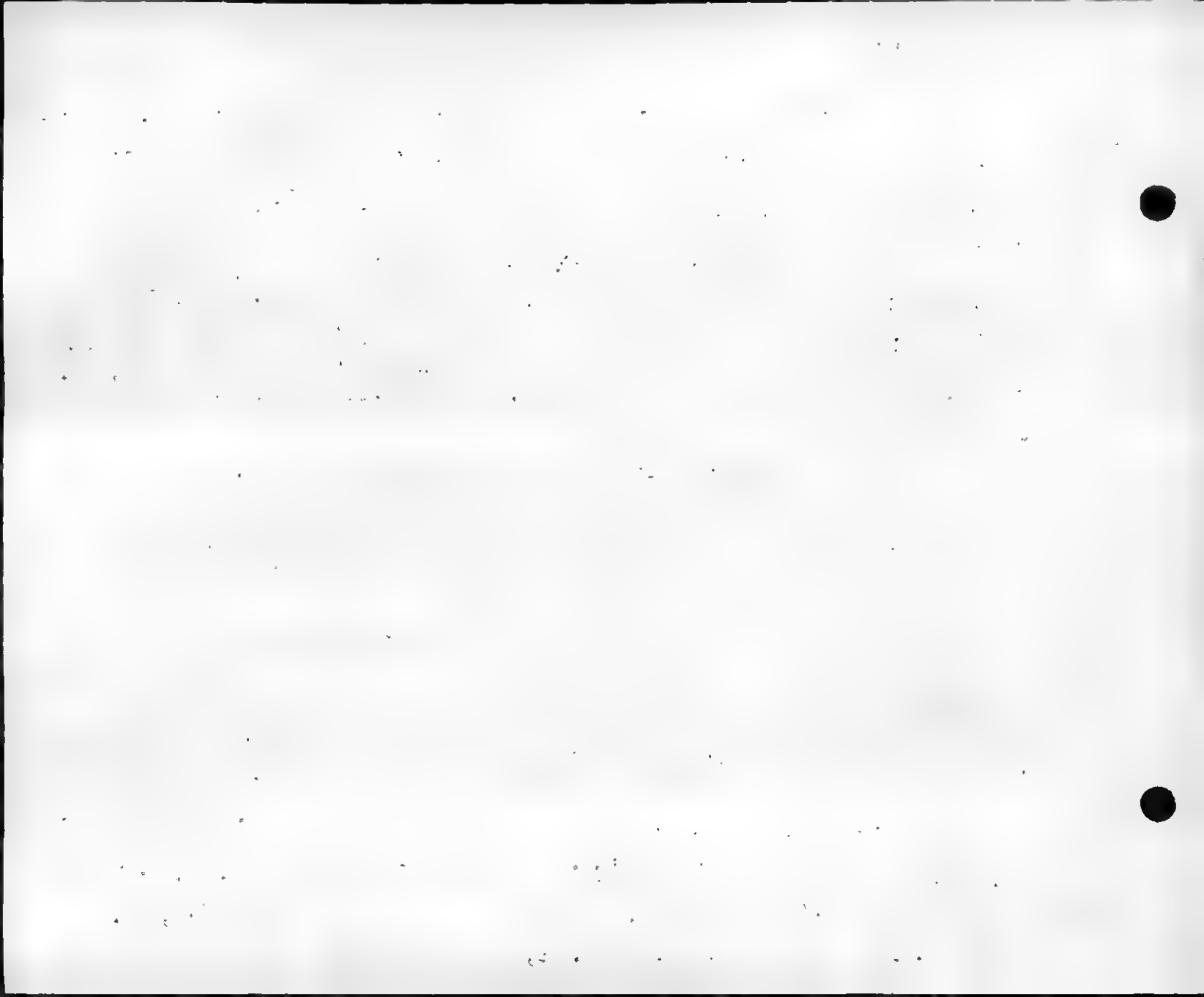
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH															
1 DECEASED NAME (Type or print)		First		Middle		Last		2a DATE OF DEATH Month Day Year			2b HOUR				
Karen		Ann		Garrison		2 28 68			8:20P ^M						
3 SEX Female		4 RACE Negro		5 DATE OF BIRTH 12/14/67			6 AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH									
Maryland		U.S.A.				Baltimore			Md						
10 CITY OR TOWN OF DEATH Owings Mills			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY						
Rosewood State Hospital						none (dependent)			--						
13a USUAL RESIDENCE (Where deceased admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER							
Maryland		-		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		620 Linard St.,							
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last	
Marvin		M.		GARRISON				Phyllis		Ann		BROOKS			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b SOCIAL SECURITY NO.		17 INFORMANT		Address									
no		---		Rosewood Records, Owings Mills, Md		21117									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Aspiration of Stomach Contents DUE TO, OR AS A CONSEQUENCE OF (b) Multiple Congenital Anomalies, Cleft palate DUE TO, OR AS A CONSEQUENCE OF (c) Macro-facial Monster Approximate interval between onset and death: Terminable 2 months															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Premature Birth, 35 wk gestation, 5 lb. 4 oz weight at Autopsy															
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		yes							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR AM Month Day Year 8:20P ^M 2 28 1968		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from 2/26/1968, to 2/28/1968, that (I) (we) last saw the deceased alive on 2/28/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b SIGNATURE		22c DATE SIGNED													
Richard A. Jones		2/28/68													
22d PHYSICIAN'S NAME (Type)		22e. ADDRESS													
Richard A. Jones,		Rosewood State Hosp., Owings Mills, Md.													
23a BURIAL, CREMATION, (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)					
Burial		March 4, 68		Rosewood Cemetery		Owings Mills, Md.									
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
J. F. Eline & Sons		Reisterstown, Md.		DATE MAR 6 1968		Charles Judge									



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<div style="text-align: center;"> <div>02191</div> <div> <div>MD</div> <div> <div>02180</div> <div>02180</div> </div> </div> </div>																	
1. DECEASED NAME (Type or print)			First Jeffrey			Middle A.			Last G E A R			2a. DATE OF DEATH Month February Day 22 Year 1968			2b. HOUR 9:35AM		
3. SEX Male			4. RACE White			5. DATE OF BIRTH April 4, 1967			6. AGE (In years last birthday) YRS 10 MONTHS 17 DAYS			IF UNDER 1 YEAR MONTHS 10 DAYS 17			IF UNDER 24 HRS. HOURS 17 MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore, Md								
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) ST. JOSEPH HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Dundalk			13d. INS. OF CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 3480 Loganview Drive					
14. FATHER'S NAME First Herbert			Middle Gear			Last Gielner			15. MOTHER'S MAIDEN NAME First Kathleen			Middle Gielner			Last Gielner		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO. None			17. INFORMANT (Father) Mr. Herbert Gear, 3480 Loganview Drive,			Address Dundalk, Md.								
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia and septicemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS (CONTRIBUTING TO DEATH) BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that NO (this hospital) attended the deceased from 2/16/ 19 68 , to 2/22/ 19 68 , that (X) (we) last saw the deceased alive on 2/22/ 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Ludilina M. Oteyza			DEGREE M.D.			ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED February 22, 1968								
22d. PHYSICIAN'S NAME (Type) Ludilina M. Oteyza, M.D.			22e. ADDRESS 7620 York Rd., Towson, Md. 21204														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 2/24/68			23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus			23d. LOCATION (City or Town) (County) (State) Baltimore, Md.								
24. FUNERAL DIRECTOR John J. Duda, 2829 Hudson St. Balto. Md,			ADDRESS 2829 Hudson St. Balto. Md,			25a. REC'D BY REGISTRAR DATE FEB 26 1968			25b. REGISTRAR'S SIGNATURE Charles Judge								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

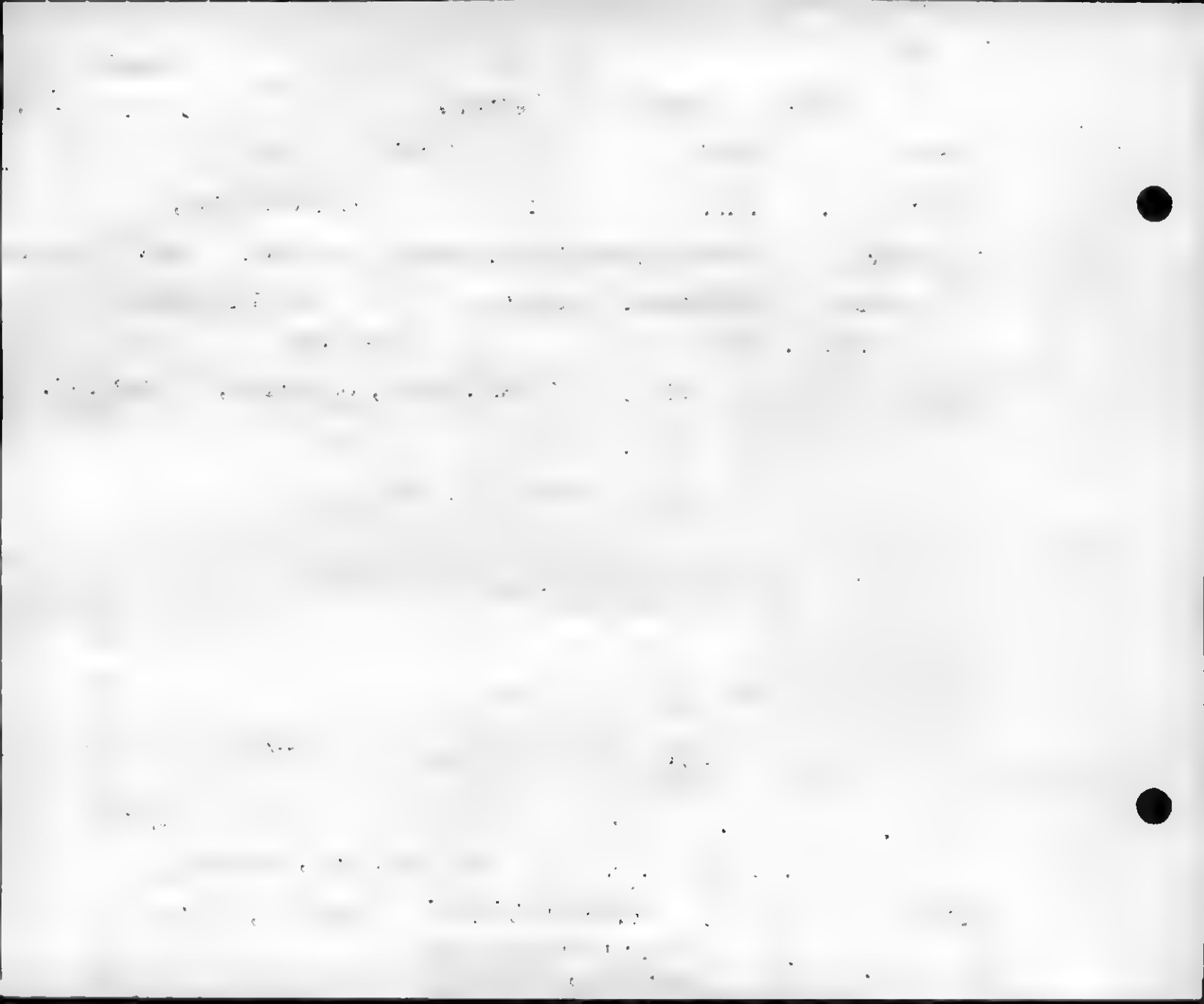
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VR AIS (4)
30M REV. 1/68

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First THOMAS			Middle KENNETH			Last GERACI		
2a. DATE OF DEATH			2 Month 2			Day 26			Year 68		
3 SEX MALE			4 RACE WHITE			5. DATE OF BIRTH 1/21/09			6 AGE (n years last birthday) 59		
7a BIRTHPLACE (State or foreign country) ANNAPOLIS, MD.			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE COUNTY, Md.		
10 CITY OR TOWN OF DEATH FORT HOWARD			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VETERANS ADMINISTRATION HOSPITAL			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) ATTENDANT			12b KIND OF BUSINESS OR INDUSTRY SERVICE STATION		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND			13b CO. CITY ANNE ARUNDEL			13c CITY OR TOWN ANNAPOLIS			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e STREET AND NUMBER 165 Green Street			14 FATHER'S NAME First FRANK B. GERACI			15 MOTHER'S MAIDEN NAME First AGNES SMITH			Last AGNES SMITH		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? YES (If yes give war or dates of service) WW II			6b SOCIAL SECURITY NO 214 05 04 08			17 INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA											
DUE TO, OR AS A CONSEQUENCE OF (b) FATTY INFILTRATION OF LIVER											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ARTERIOSCLEROTIC HEART DISEASE AND CHRONIC BRAIN SYNDROME											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street factory, office building, etc.)			21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (1) (this hospital) attended the deceased from 2/22/68 , 19 68 , to 2/26/68 , 19 68 , that (2) (we) last saw the deceased alive on 2/26/68 , 19 68 , and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above (4) (we) (did) (did not) view the body after death.											
22b SIGNATURE J. D. Talbert, M.D.									22c DATE SIGNED 2/26/68		
22d PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.									22e ADDRESS VAH FORT HOWARD, MARYLAND		
23a. BURIAL, CREMATION, or other disposition (Specify) BURIAL			23b DATE 2-29-68			23c NAME OF CEMETERY OR CREMATORY ST. MARY'S CEMETERY			23d LOCATION (City or Town) (County) (State) ANNAPOLIS, MARYLAND		
24 FUNERAL DIRECTOR John M. Taylor & Sons.						25a REC'D BY REGISTRAR DATE FEB 28 1968			25b REGISTRAR'S SIGNATURE Charles Judge		

TAYLOR'S FUNERAL HOME
ANNAPOLIS, MARYLAND



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

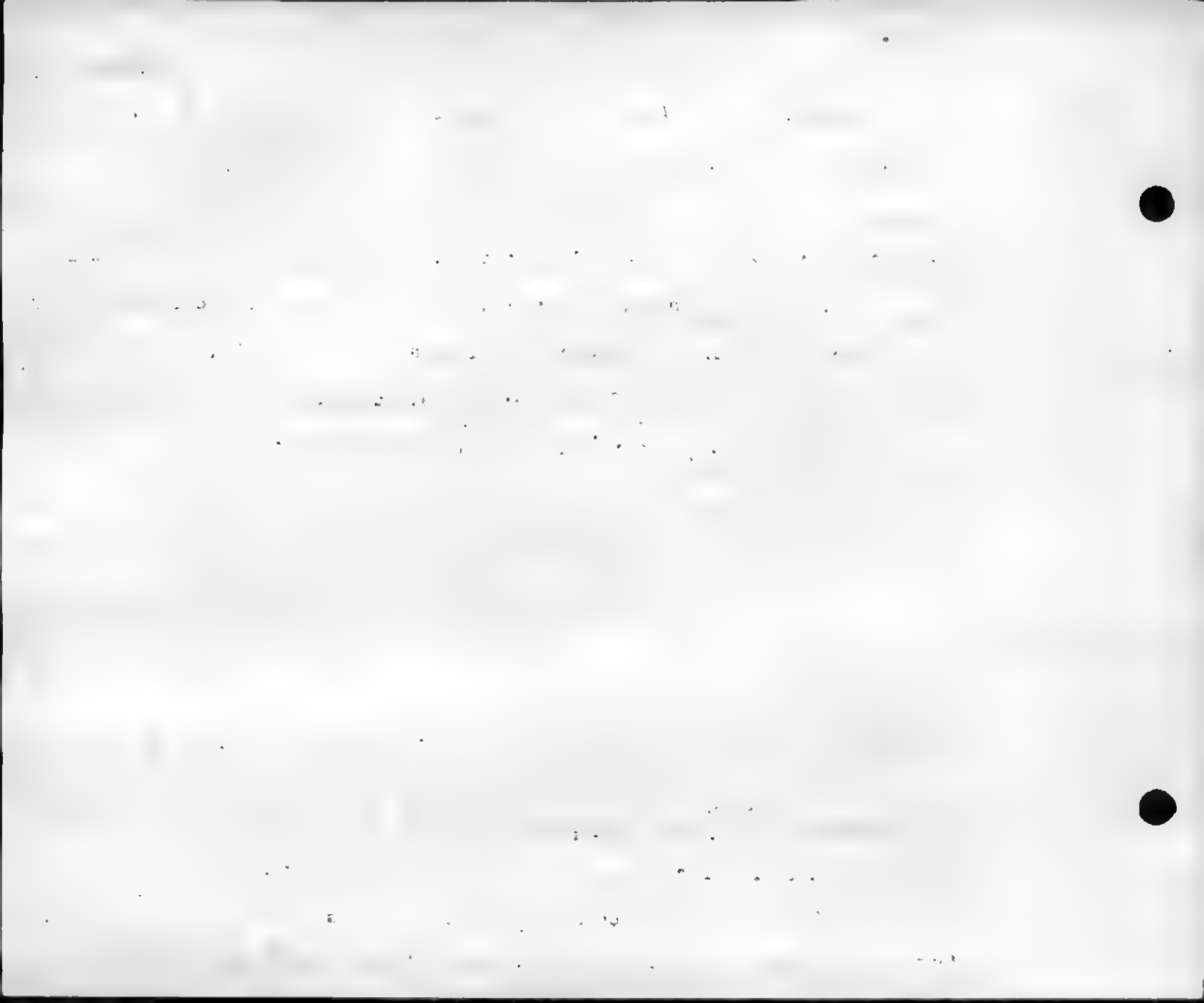
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

Item 18 Film 398 2-28-68 am MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

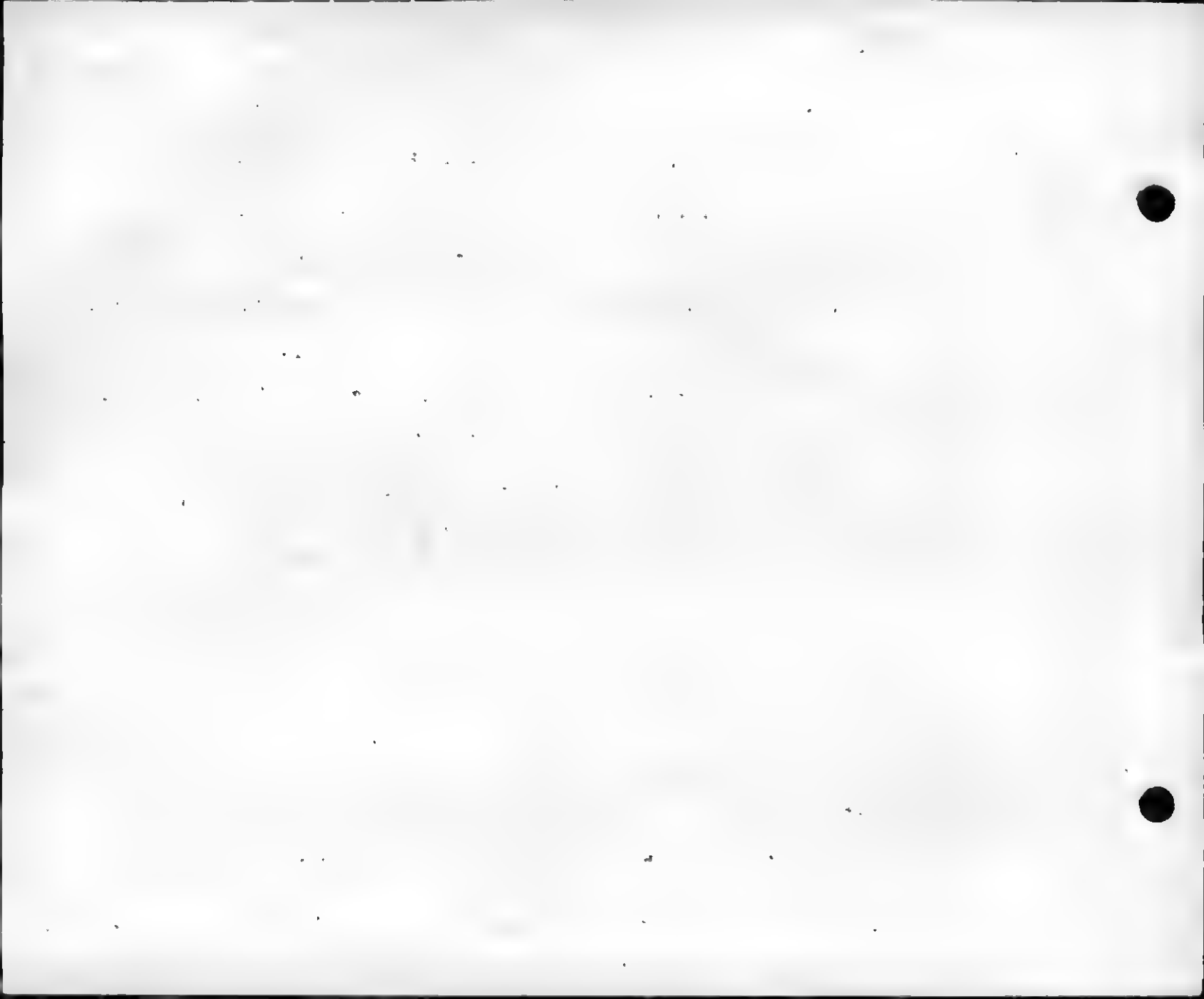
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b. HOUR		
Patricia Ann Gerber						Month Day Year 2 14 68			M		
3 SEX			4. RACE			5. DATE OF BIRTH			6 AGE (n years past birthday)		
Female			White			6/22/30			37 YRS		
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Maryland			USA						Baltimore Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even retired)			12b KIND OF BUSINESS OR INDUSTRY		
Baltimore Catonsville			443 Chalfonte Dr.			Housewife			-		
13a U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Md.			Balto.			Balto.			443 Chalfonte Drive 21228		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
John L. Cooper			Thelma T. Marvel								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO			17 INFORMANT			Address		
No			213-30-3173			William J. Gerber, 443 Chalfonte Drive			21228		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>metastatic Carcinoma</u> 114 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Primary Breast</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> DUE TO, OR AS A CONSEQUENCE OF											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
110 X											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No City or Town County State					
22a I certify that (I) (this hospital) attended the deceased from <u>5/25, 1964</u> , to <u>2/15 1968</u> , that (I) (we) last saw the deceased alive on <u>2/14 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <u>James N. Frederick</u> DEGREE						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c DATE SIGNED <u>2/15/68</u>		
22d PHYSICIAN'S NAME (Type) Dr. James Frederick						22e ADDRESS 1311 Francis Ave.					
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			2/17/68			Loudon Park Cemetery			Baltimore Md.		
24 FUNERAL DIRECTOR Howard H. Hubbard , 4107 Wilkens Ave. 21229						25a REC'D BY REGISTRAR DATE FEB 20 1968			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

MAYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)		First		Middle		Last		2a DATE OF DEATH Month Day Year	
Frederick				Gerstley				2 23 1968	
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7b IF UNDER 1 YEAR MONTHS DAYS	
Male		White		9-8-1884		83 YRS			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b KIND OF BUSINESS OR INDUSTRY	
Barnmouth Mass		U.S.A.				Baltimore		Rubberoid C	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		13e STREET AND NUMBER			
Fullerton		3219 Belair Road		Superent		21236			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		3d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Md.		Baltimore		Fullerton		x			
14. FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME	
Arthur Gerstley								Mary	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO.		17 INFORMANT		Address			
No		212-01-0441		Mrs Eugenia Gerstley		3219 Belair Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Other atherosclerotic Cardiovascular Disease</u>								undet.	
4121 CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) <u>2 Parkinsonism and Cerebral vascular disease</u>									
(c) <u>3-4 yrs standing</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
4121									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21c LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>10-15</u> , 19 <u>68</u> , to <u>2-23</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>19 Feb</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE		22c. DATE SIGNED							
<u>John C. Hyle</u> M.D.		2-23-68							
22d PHYSICIAN'S NAME (Type)		22e ADDRESS							
JOHN C. Hyle		7527 Belair Rd Baltimore							
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		2-21-1968		Parkwood Cemetery		Baltimore Co. Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Lorraine Funeral Home		7401 Belair Rd 36		FEB 26 1968		<u>Charles Jones</u>			

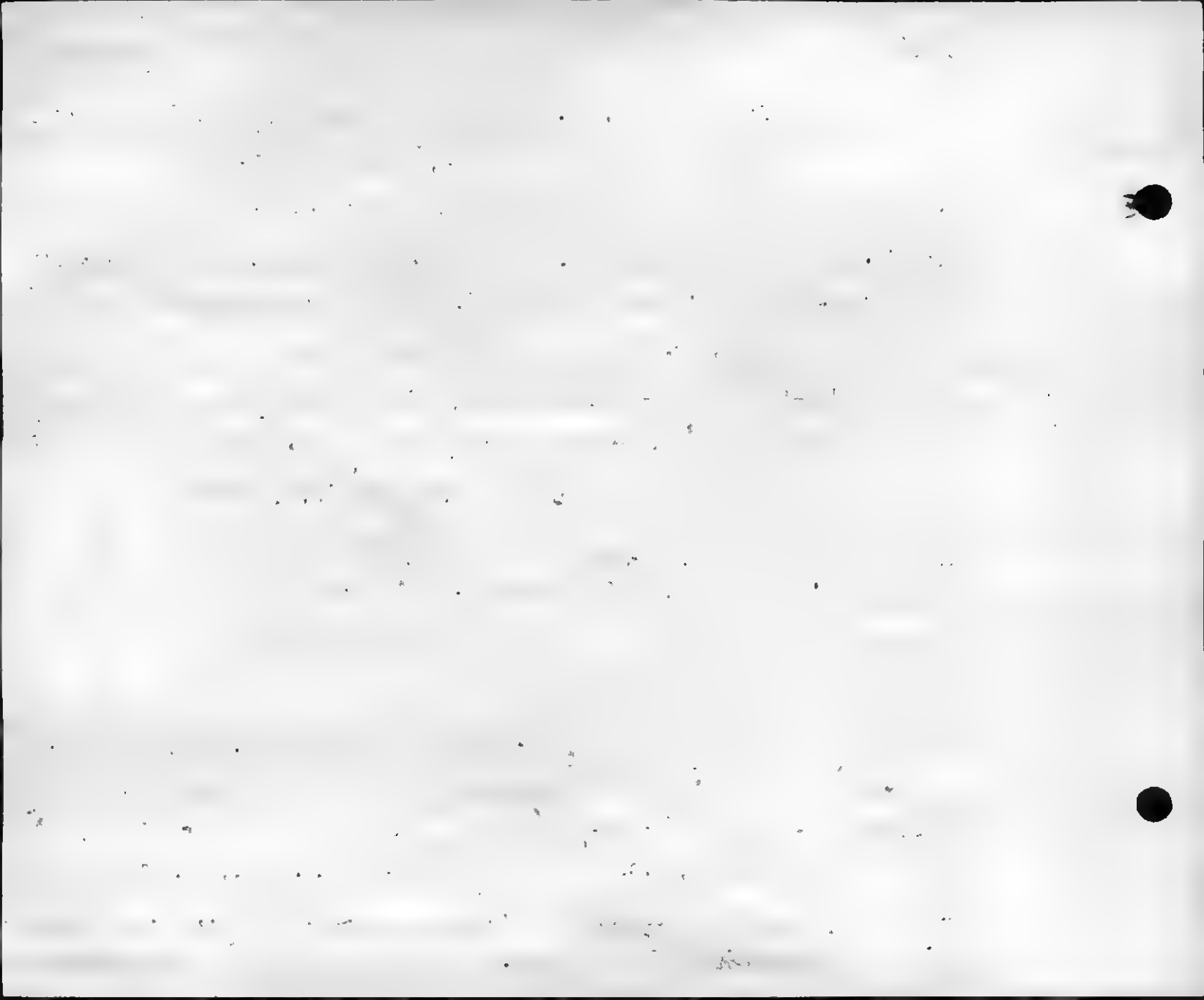


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VR A15 (4)
30M REV 1/68

<div style="display: flex; justify-content: space-between;"> 02195 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02184 </div> <div style="text-align: center; font-weight: bold; font-size: 1.2em;">CERTIFICATE OF DEATH</div>											
1. DECEASED-NAME (Type or print) First Middle Last THOMAS FENTON GILL, JR.						2a. DATE OF DEATH Month Day Year February 13, 1968			2b. HOUR PM 2:15		
3 SEX Male		4 RACE White		5. DATE OF BIRTH May 18, 1928			6. AGE (In years last birthday) 39 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md.				
10. CITY OR TOWN OF DEATH Essex (21)			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 149 Bladen Rd.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) General Manager			12b. KIND OF BUSINESS OR INDUSTRY Restaurant	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Essex (21)		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 149 Bladen Road		
14. FATHER'S NAME First Middle Last Thomas B. Gill, Sr.						15. MOTHER'S MAIDEN NAME First Middle Last Catherine Pitman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes				16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 46-148		17. INFORMANT Ellen Gill			Address Same		
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary atherosclerotic coronary vas. disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>2 yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4701</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes mellitus, essentially permanent</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 13, 1967</u> , to <u>Feb 13, 1968</u> , that (I) (we) last saw the deceased alive on <u>Feb 13, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE <u>Louis Semenoff, M.D.</u>						DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>2/14/68</u>	
22d. PHYSICIAN'S NAME (Type) Louis Semenoff, M.D.						22e. ADDRESS 2108 Orems Rd. Balto., Md. 21220					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/16/68		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore Co., Md.				
24. FUNERAL DIRECTOR Bruzdzinski Funeral Home 1407 Eastern Ave.						ADDRESS		25a. REC'D BY REGISTRAR DATE FEB 15 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



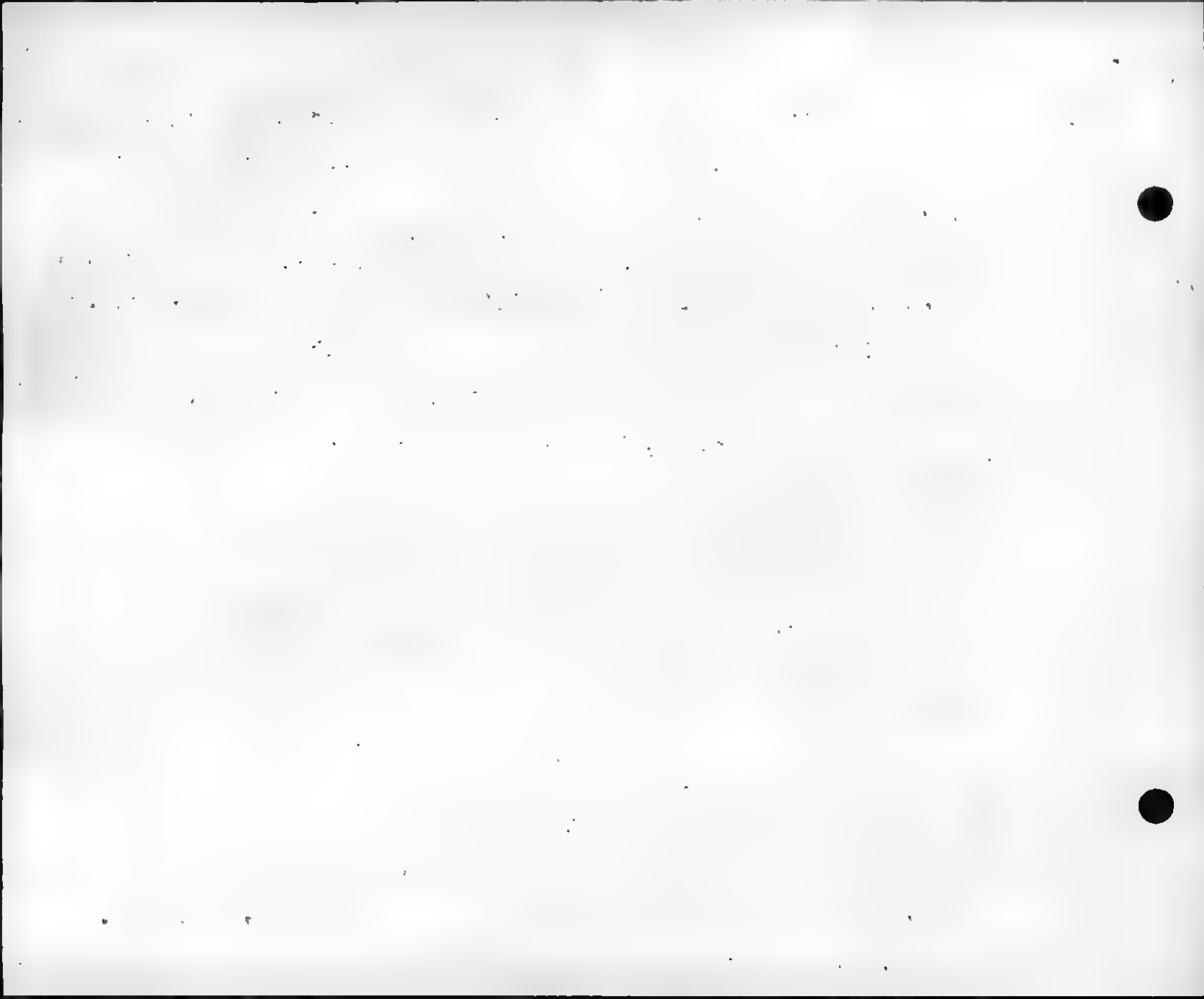
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VR A15 (4)
304A REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) DR. LOUIS			First Middle Last J. GLASS			2a DATE OF DEATH Month Day Year FEBRUARY 29, 1968			2b HOUR 10:05 A.M.
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH SEPT. 15, 1904			6 AGE (In years last birthday) 63 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (State or foreign country) BALTIMORE, MD.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH BALTIMORE Md			
10. CITY OR TOWN OF DEATH PIKESVILLE			11 NAME OF HOSPITAL OR INSTITUTION (Give street address) COURT ROAD EDEN ROC WAY & OLD			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) PHYSICIAN			12b KIND OF BUSINESS OR INDUSTRY MEDICAL
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND			13b COUNTY BALTIMORE		13c CITY OR TOWN PIKESVILLE		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER EDEN ROC WAY #21208
14. FATHER'S NAME First Middle Last SIMON GLASS			15. MOTHER'S MAIDEN NAME First Middle Last JENNIE MILLER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) NO			16b. SOCIAL SECURITY NO		17 INFORMANT Address MRS. MILDRED GLASS, EDEN ROC WAY & OLD COURT RD.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRAIN TUMOR (GLIOBLASTOMA MULTIFORME) 191X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 MOS.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a DATE OF OPERATION 12/9/67		19b CONDITION FOR WHICH OPERATION WAS PERFORMED BRAIN TUMOR			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)			21f LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 12/9 , 19 67 , to 2/28 , 19 68 , that (I) (we) last saw the deceased alive on 2/28 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Israel W. Weiner, M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED 2/29/68			
22d. PHYSICIAN'S NAME (Type) ISRAEL WEINER						22e. ADDRESS 6222 WOODCREST AVENUE			
23a BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3-1-68		23c. NAME OF CEMETERY OR CREMATORY BETH TFILOH			23d. LOCAT ON (City or Town) (County) (State) BALTIMORE MARYLAND		
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN				ADDRESS ROAD		25a. REC'D BY REG. STRAR DATE MAR 5 1968		25b. REGISTRAR'S SIGNATURE [Signature]	

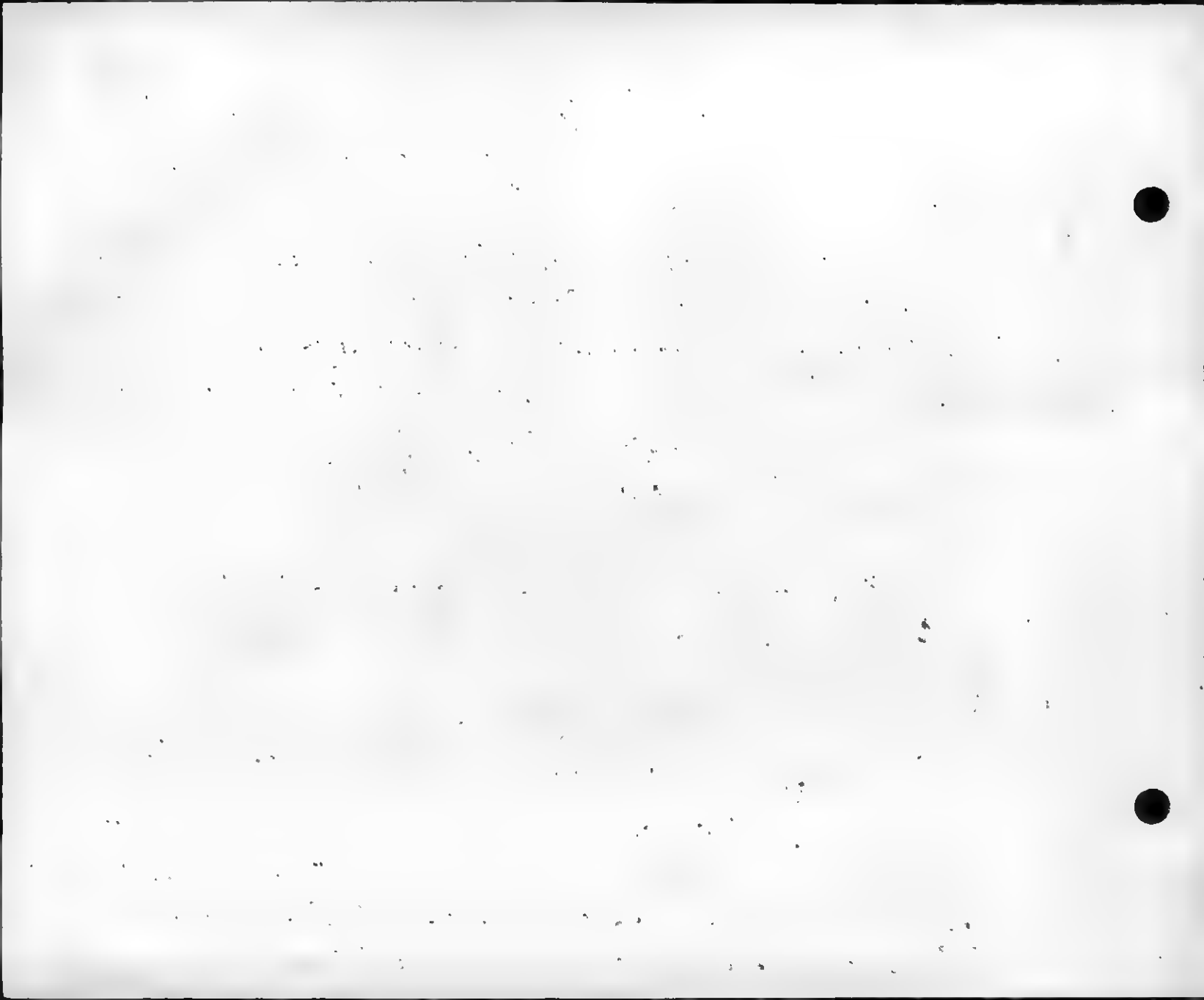
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH </div>											
1. DECEASED NAME (Type or print) First Middle Last WILLIAM AUGUST GOENNER, JR.						2a. DATE OF DEATH 2 Month 20 Day 1968 Year			2b. HOUR M		
3. SEX M		4. RACE W		5. DATE OF BIRTH 3-19-1888		6. AGE (In years last birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ARMACOST NURSING HOME				12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) PAINTER			12b. KIND OF BUSINESS OR INDUSTRY PAINTING.		
13a. USUAL RESIDENCE (Where deceased lived, if institution, Res. since before admission) STATE MARYLAND		13b. COUNTY BALT V		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 521 N. STREEPER ST.			
14. FATHER'S NAME First Middle Last WILLIAM AUGUST GOENNER SR.				15. MOTHER'S MAIDEN NAME First Middle Last MARY GEPHART.							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No				16b. SOCIAL SECURITY NO		17. INFORMANT Ysabelia M. Goenner Address 521 N. Streper Cr.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) metastatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma? etiology DUE TO, OR AS A CONSEQUENCE OF last. 1968 (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) arteriosclerotic cardiovascular disease											
19a. DATE OF OPERATION none		19b. CONDITION FOR WHICH OPERAT ON WAS PERFORMED none		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 2/15 , 19 68 , to 2/20 , 19 68 , that (I) (we) last saw the deceased alive on 2/19 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Alan Tapper M.D.				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE/SIGNED 2/21/68			
22d. PHYSICIAN'S NAME (Type) ALAN TAPPER M.D.				22e. ADDRESS 7501 YORK RD. TOLSON MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 2-23-68		23c. NAME OF CEMETERY OR CREMATORY LORRAINE PARK MASOLEUM.		23d. LOCATION (City or Town) (County) (State) BALTO. MD.					
24. FUNERAL DIRECTOR Harry Miller - 2334 Jefferson St.				ADDRESS		25a. REC'D BY REGISTRAR FEB 23 1968		25b. REGISTRAR'S SIGNATURE John Charles Judge			

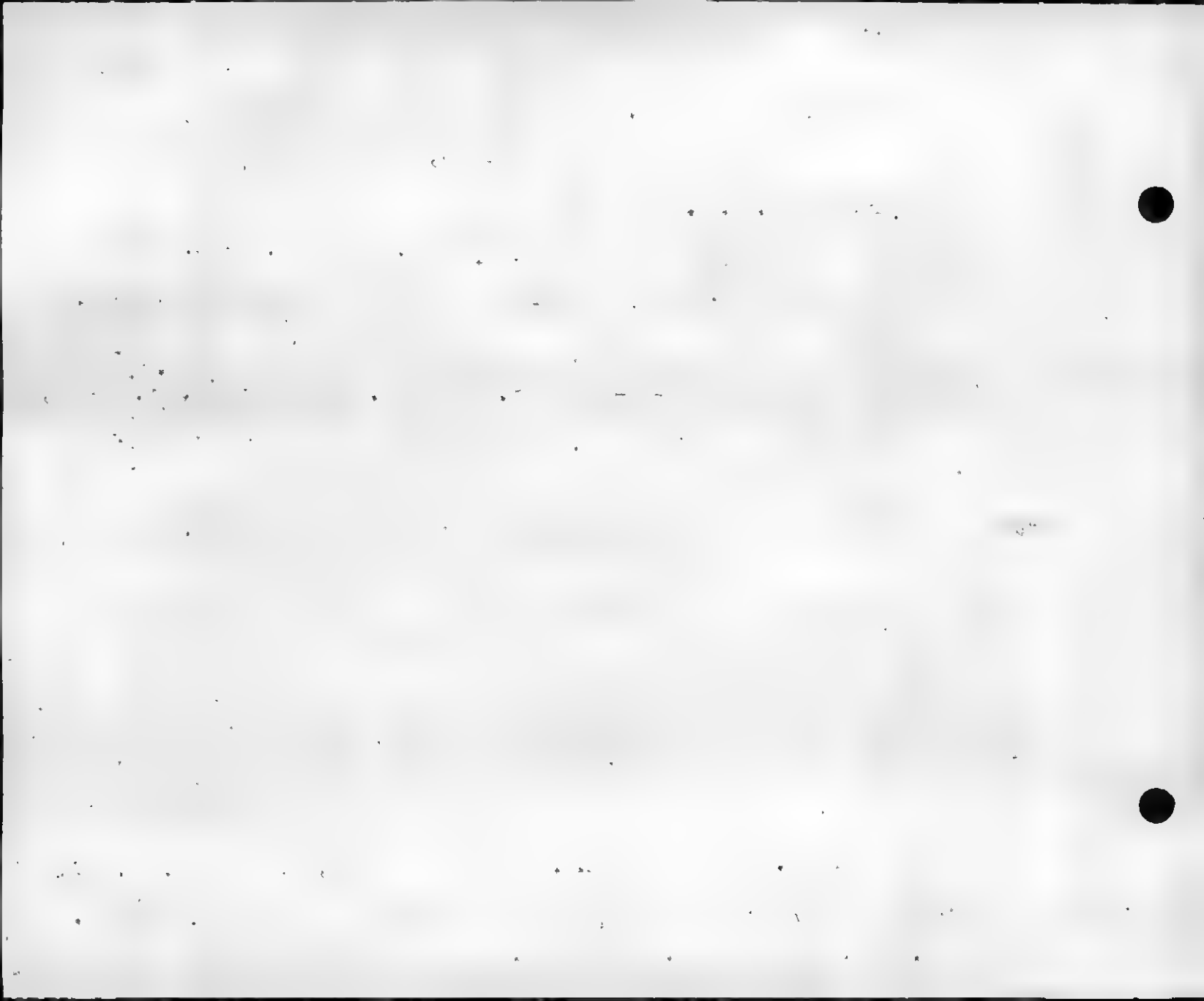


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 4 and 5 and 6 and 7 and 8 and 9 and 10 and 11 and 12 and 13 and 14 and 15 and 16 and 17 and 18 and 19 and 20 and 21 and 22 and 23 and 24 and 25 and 26 and 27 and 28 and 29 and 30 and 31 and 32 and 33 and 34 and 35 and 36 and 37 and 38 and 39 and 40 and 41 and 42 and 43 and 44 and 45 and 46 and 47 and 48 and 49 and 50 and 51 and 52 and 53 and 54 and 55 and 56 and 57 and 58 and 59 and 60 and 61 and 62 and 63 and 64 and 65 and 66 and 67 and 68 and 69 and 70 and 71 and 72 and 73 and 74 and 75 and 76 and 77 and 78 and 79 and 80 and 81 and 82 and 83 and 84 and 85 and 86 and 87 and 88 and 89 and 90 and 91 and 92 and 93 and 94 and 95 and 96 and 97 and 98 and 99 and 100 and 101 and 102 and 103 and 104 and 105 and 106 and 107 and 108 and 109 and 110 and 111 and 112 and 113 and 114 and 115 and 116 and 117 and 118 and 119 and 120 and 121 and 122 and 123 and 124 and 125 and 126 and 127 and 128 and 129 and 130 and 131 and 132 and 133 and 134 and 135 and 136 and 137 and 138 and 139 and 140 and 141 and 142 and 143 and 144 and 145 and 146 and 147 and 148 and 149 and 150 and 151 and 152 and 153 and 154 and 155 and 156 and 157 and 158 and 159 and 160 and 161 and 162 and 163 and 164 and 165 and 166 and 167 and 168 and 169 and 170 and 171 and 172 and 173 and 174 and 175 and 176 and 177 and 178 and 179 and 180 and 181 and 182 and 183 and 184 and 185 and 186 and 187 and 188 and 189 and 190 and 191 and 192 and 193 and 194 and 195 and 196 and 197 and 198 and 199 and 200 and 201 and 202 and 203 and 204 and 205 and 206 and 207 and 208 and 209 and 210 and 211 and 212 and 213 and 214 and 215 and 216 and 217 and 218 and 219 and 220 and 221 and 222 and 223 and 224 and 225 and 226 and 227 and 228 and 229 and 230 and 231 and 232 and 233 and 234 and 235 and 236 and 237 and 238 and 239 and 240 and 241 and 242 and 243 and 244 and 245 and 246 and 247 and 248 and 249 and 250 and 251 and 252 and 253 and 254 and 255 and 256 and 257 and 258 and 259 and 260 and 261 and 262 and 263 and 264 and 265 and 266 and 267 and 268 and 269 and 270 and 271 and 272 and 273 and 274 and 275 and 276 and 277 and 278 and 279 and 280 and 281 and 282 and 283 and 284 and 285 and 286 and 287 and 288 and 289 and 290 and 291 and 292 and 293 and 294 and 295 and 296 and 297 and 298 and 299 and 300 and 301 and 302 and 303 and 304 and 305 and 306 and 307 and 308 and 309 and 310 and 311 and 312 and 313 and 314 and 315 and 316 and 317 and 318 and 319 and 320 and 321 and 322 and 323 and 324 and 325 and 326 and 327 and 328 and 329 and 330 and 331 and 332 and 333 and 334 and 335 and 336 and 337 and 338 and 339 and 340 and 341 and 342 and 343 and 344 and 345 and 346 and 347 and 348 and 349 and 350 and 351 and 352 and 353 and 354 and 355 and 356 and 357 and 358 and 359 and 360 and 361 and 362 and 363 and 364 and 365 and 366 and 367 and 368 and 369 and 370 and 371 and 372 and 373 and 374 and 375 and 376 and 377 and 378 and 379 and 380 and 381 and 382 and 383 and 384 and 385 and 386 and 387 and 388 and 389 and 390 and 391 and 392 and 393 and 394 and 395 and 396 and 397 and 398 and 399 and 400 and 401 and 402 and 403 and 404 and 405 and 406 and 407 and 408 and 409 and 410 and 411 and 412 and 413 and 414 and 415 and 416 and 417 and 418 and 419 and 420 and 421 and 422 and 423 and 424 and 425 and 426 and 427 and 428 and 429 and 430 and 431 and 432 and 433 and 434 and 435 and 436 and 437 and 438 and 439 and 440 and 441 and 442 and 443 and 444 and 445 and 446 and 447 and 448 and 449 and 450 and 451 and 452 and 453 and 454 and 455 and 456 and 457 and 458 and 459 and 460 and 461 and 462 and 463 and 464 and 465 and 466 and 467 and 468 and 469 and 470 and 471 and 472 and 473 and 474 and 475 and 476 and 477 and 478 and 479 and 480 and 481 and 482 and 483 and 484 and 485 and 486 and 487 and 488 and 489 and 490 and 491 and 492 and 493 and 494 and 495 and 496 and 497 and 498 and 499 and 500 and 501 and 502 and 503 and 504 and 505 and 506 and 507 and 508 and 509 and 510 and 511 and 512 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and 638 and 639 and 640 and 641 and 642 and 643 and 644 and 645 and 646 and 647 and 648 and 649 and 650 and 651 and 652 and 653 and 654 and 655 and 656 and 657 and 658 and 659 and 660 and 661 and 662 and 663 and 664 and 665 and 666 and 667 and 668 and 669 and 670 and 671 and 672 and 673 and 674 and 675 and 676 and 677 and 678 and 679 and 680 and 681 and 682 and 683 and 684 and 685 and 686 and 687 and 688 and 689 and 690 and 691 and 692 and 693 and 694 and 695 and 696 and 697 and 698 and 699 and 700 and 701 and 702 and 703 and 704 and 705 and 706 and 707 and 708 and 709 and 710 and 711 and 712 and 713 and 714 and 715 and 716 and 717 and 718 and 719 and 720 and 721 and 722 and 723 and 724 and 725 and 726 and 727 and 728 and 729 and 730 and 731 and 732 and 733 and 734 and 735 and 736 and 737 and 738 and 739 and 740 and 741 and 742 and 743 and 744 and 745 and 746 and 747 and 748 and 749 and 750 and 751 and 752 and 753 and 754 and 755 and 756 and 757 and 758 and 759 and 760 and 761 and 762 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and 888 and 889 and 890 and 891 and 892 and 893 and 894 and 895 and 896 and 897 and 898 and 899 and 900 and 901 and 902 and 903 and 904 and 905 and 906 and 907 and 908 and 909 and 910 and 911 and 912 and 913 and 914 and 915 and 916 and 917 and 918 and 919 and 920 and 921 and 922 and 923 and 924 and 925 and 926 and 927 and 928 and 929 and 930 and 931 and 932 and 933 and 934 and 935 and 936 and 937 and 938 and 939 and 940 and 941 and 942 and 943 and 944 and 945 and 946 and 947 and 948 and 949 and 950 and 951 and 952 and 953 and 954 and 955 and 956 and 957 and 958 and 959 and 960 and 961 and 962 and 963 and 964 and 965 and 966 and 967 and 968 and 969 and 970 and 971 and 972 and 973 and 974 and 975 and 976 and 977 and 978 and 979 and 980 and 981 and 982 and 983 and 984 and 985 and 986 and 987 and 988 and 989 and 990 and 991 and 992 and 993 and 994 and 995 and 996 and 997 and 998 and 999 and 1000.

MD198
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Thomas E. Good			2a. DATE OF DEATH Month Day Year February 9 1968			2b. HOUR M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH July 11, 1880		6. AGE (In years last birthday) 87 YRS		IF UNDER 1 YEAR MONTHS DAYS F UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md			
10. CITY OR TOWN OF DEATH Edgemere		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7319 North Dakota Ave.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Labor Work		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Edgemere		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 7319 North Dakota Ave.	
14. FATHER'S NAME First Middle Last Jacob Good			15. MOTHER'S MAIDEN NAME First Middle Last Sarah Anderson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 218-03-9035		17. INFORMANT (Son) Mr. William J. Good, Todd Ave. Ft. Howard,		Address Md. 21219			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Gastrointestinal hemorrhage</u> 5699 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HR	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Jan 12, 1968, to Feb 9, 1968, that (I) (we) last saw the deceased alive on Feb 7, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John V. Conway M.D.						DEGREE M.D.		22c. DATE SIGNED 2-12-68	
22d. PHYSICIAN'S NAME (Type) John V. Conway						22e. ADDRESS 914 "D" Street, Sparrows Pt. Md. 21219			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/13/68		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Bel Air Md.			
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.						25a. REC'D BY REGISTRAR DATE FEB 14 1968		25b. REGISTRAR'S SIGNATURE	



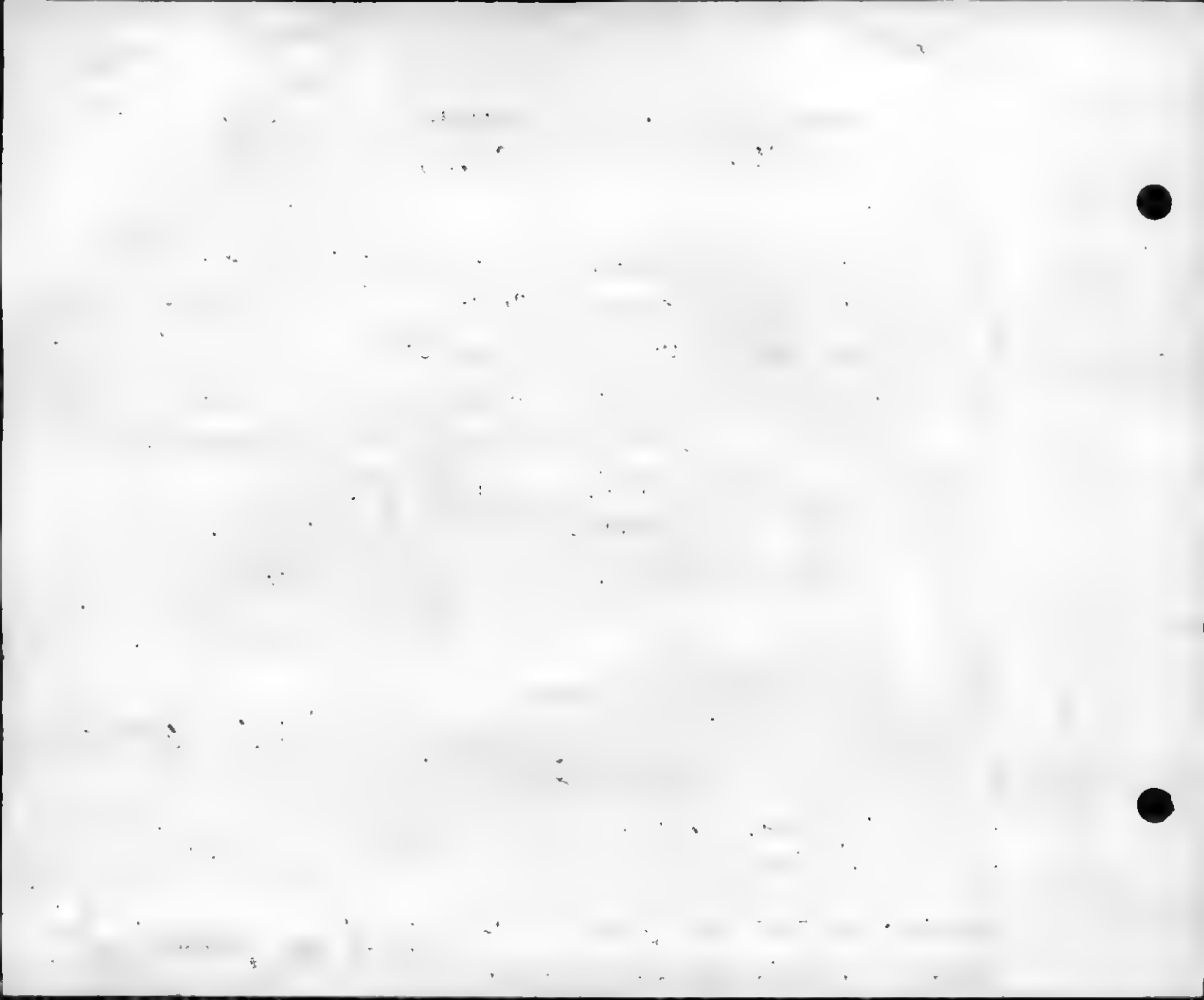
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <i>Charles T. Goodwin</i>			2a. DATE OF DEATH Month Day Year <i>Feb. 17 1968</i>		2b. HOUR 8:40 PM
3. SEX <i>male</i>	4. RACE <i>white</i>	5. DATE OF BIRTH <i>Oct. 24, 1894</i>		6. AGE (In years lost birthday) <i>73</i> YRS.	7. UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTH-PLACE (State or foreign country) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Baltimore</i> Md		
10. CITY OR TOWN OF DEATH <i>Baltimore 21234</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>8706 Edgely Road</i>		12a. USUAL OCCUPATION (Kind of work done during most of work night, even if retired) <i>Maritime Watchman</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Baltimore</i>	13c. CITY OR TOWN <i>Balto. 34</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>8706 Edgely Road</i>	
14. FATHER'S NAME First Middle Last <i>Charles T. Goodwin</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Mary Fraley</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>yes</i> (If in Armed Forces of service)		16b. SOCIAL SECURITY NO <i>219129688</i>	17. INFORMANT <i>Blanche Goodwin</i>		Address <i>same</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardiovascular Disease</i> <i>with Coronary Insufficiency</i> DUE TO, OR AS A CONSEQUENCE OF + accompanied by <i>Cerebro Vascular insufficiency</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Old Cerebrovascular occlusion with partial Hemiparesis</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, not by medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <i>Feb 16 1968</i> to <i>Feb 18 1968</i> , that (I) (we) last saw the deceased alive on <i>Feb 16 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Frank Rask Jr.</i>			22c. DATE SIGNED <i>2/18/68</i>		
22d. PHYSICIAN'S NAME (Type) <i>FRANK RASK JR.</i>			22e. ADDRESS <i>9005 Harford Rd Balto Md</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>2-20-68</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Glen Burnie, Md.</i>	
24. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc Baltimore, Md.</i>			25a. RECEIVED BY REGISTRAR DATE <i>FEB 19 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>

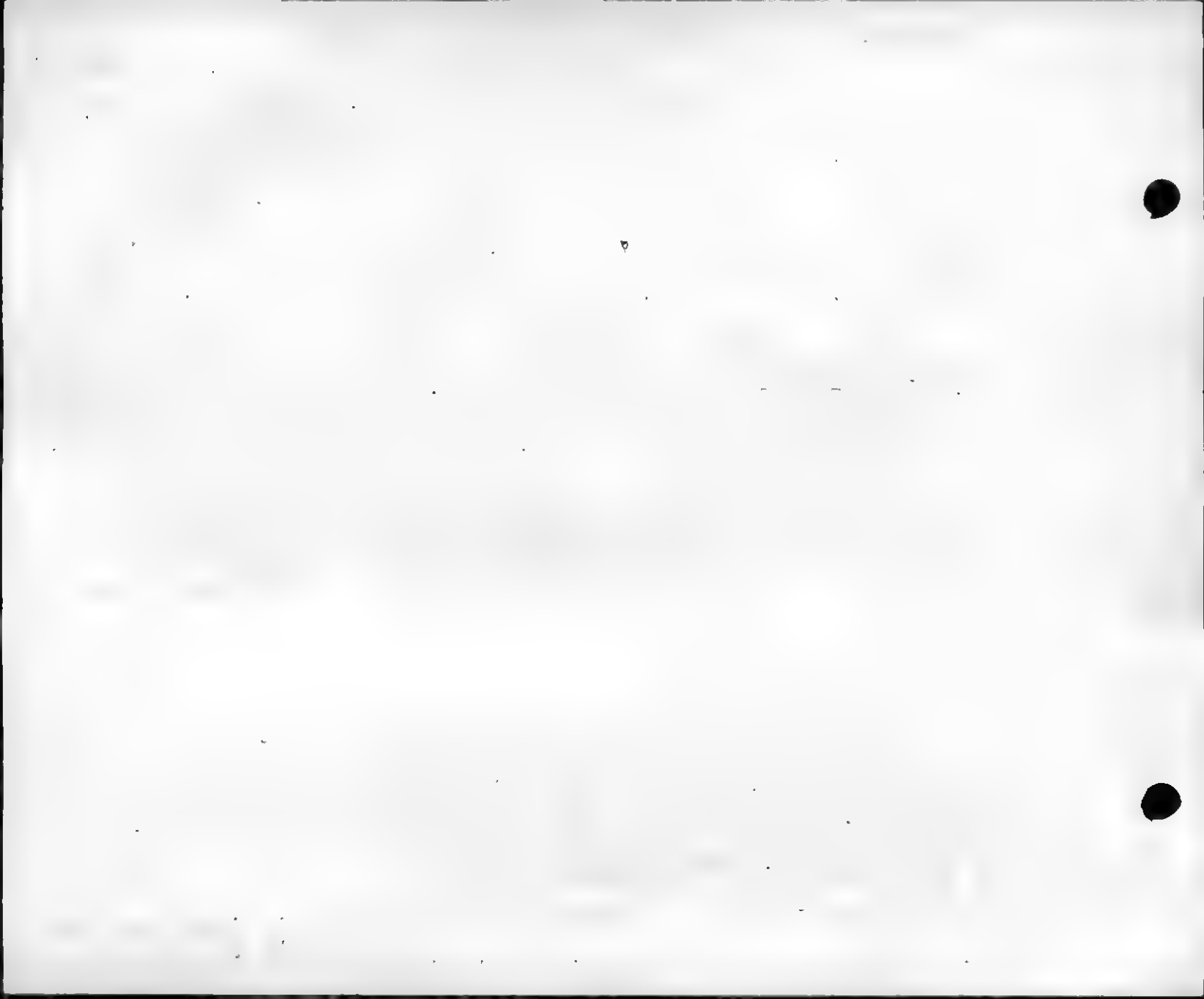


FOR STATE
HEALTH DEPT?

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1413. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or Print)		F.ist		M.iddle		Last		2a DATE KNOWN OF DEATH		2b HO. R.	
George Howard		Grinnell Jr.						Month Day Year		2b HO. R.	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		2d HOUR	
Male	Cau.	July 29, 1911	56 YRS	MONTHS	DAYS	HOURS	MIN.	Month Day Year	19 68 4 P M		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 COUNTY OF DEATH					
Brockton, Mass		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore				Md	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
Lutherville		7 Picket Rd.		Writer		Steel					
13a USUAL RESIDENCE (Where deceased lived, if institution, on Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER			
Md.		Balto.		Lutherville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7 Picket Rd.		21093	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME									
First Middle Last		First Middle Last									
George Howard Grinnell Sr.		Emma Hamilton									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS					
No		112-10-9195		George H. Grinnell III		Same					
18 CAUSE OF DEATH (Enter on y one cause per line for (a) (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carbon Monoxide Intoxication										Sudden	
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
731											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
CAUSE OF DEATH		HOUR A.M. P.M.									
21d INJURY OCCURRED		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		ASSISTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		22b DATE SIGNED			
EXAMINER'S NAME (Type)		Charles F. O'Donnell						2/13/68			
ADDRESS (Street, city, town, or county)											
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)	
Burial		2-16-1968		Prospect Hill		Balto. Md.		21204			
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
Wm. Cook-Brooks		Towson 1050 York Rd. Towson, Md		FEB 16 1968		[Signature]					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MEDICAL CERTIFICATION

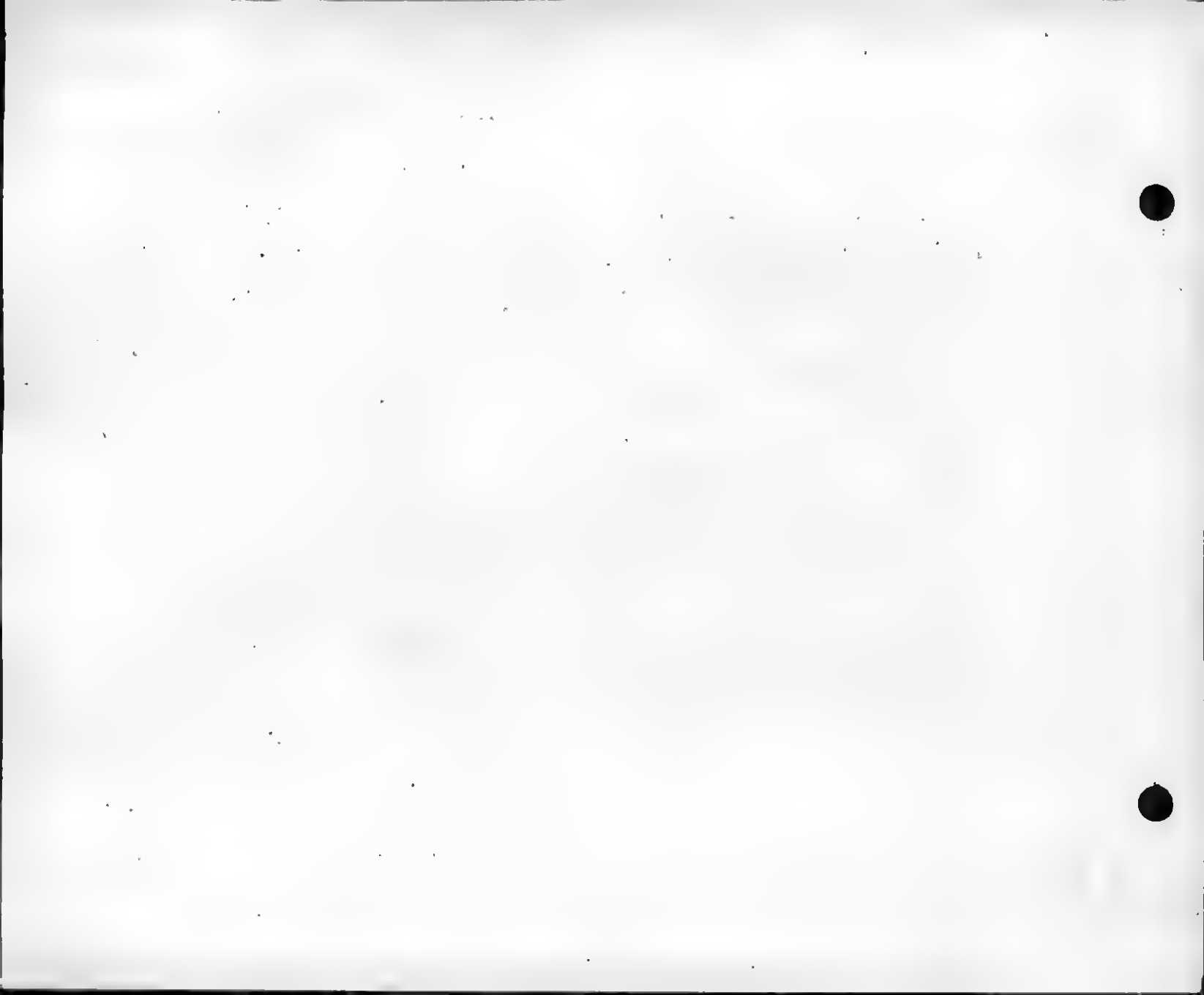
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH			2b. HOUR		
John P.M.						HAAS, JR		February 1			68		
3 SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		Dec 30, 1883				84 YRS		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						Md	
Lukens, Pa		U.S.A.				BALTIMORE							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY				
HARRISONVILLE		Chapel Hill Nursing Home				GAS & Electric Co							
13a. USUAL RESIDENCE (Where deceased lived, if not in hospital residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY - MTS?		13e. STREET AND NUMBER					
Md		Balto		Balto		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4604 Springdale Ave					
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle	
John P.M.						HAAS, SR		UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address							
No						Edwin K HAAS - 3685 18th Ave - PITTSFORD New York							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral arteriosclerosis											4 yrs.		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													
DUE TO, OR AS A CONSEQUENCE OF (b)													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
334													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
		HOUR A.M. Month Day Year											
		P.M. 19											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No		City or Town		County		State	
While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>													
22a. I certify that (I) (this hospital) attended the deceased from Jan 5, 1966, to Feb 1, 1968, that (I) (we) last saw the deceased alive on Jan 31, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		22c. DATE SIGNED				22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
Marvin Goldstein		2/2/68				MARVIN GOLDSTEIN		6001 PARK HEIGHTS AVE. BALTO, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)			
BURIAL		2-5-68		Glenwood Cemetery		WASHINGTON, D.C.							
24. FUNERAL DIRECTOR		ADDRESS				FILED BY REGISTRAR		DATE		25b. REGISTRAR'S SIGNATURE			
Ellsworth Armacost		4600 Liberty Heights Ave				FEB 5 1968				[Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the legal director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		
Julia			G.		Hamlin		Feb.		Month 25 Day 12 Year 1968		
3 SEX		4 RACE		5 DATE OF BIRTH				6. AGE (In years last birthday)		7b. HOUR	
Female		White		Jan. 30, 1832				56 YRS		M	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Minn.			U.S.A.					Baltimore Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Randalstown			Chapel Hill Nursing Hl.			Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.						Balto.				21215	
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME		
Jaram			Parke		Hamlin				Minnie Dwinell		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
			220-43-0465			Mrs. Jane G. Brooks			3617 Spalding Ave		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH CAUSED BY:										2 HRS	
IMMEDIATE CAUSE (a) CORONARY INFARCTION											
4107 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										10 YRS	
(b) ASCVD.											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 1B.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from 11:30 AM to 2-26-68, that (I) (we) last saw the deceased alive on 2-26-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED				22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
R.V. Houck, M.D.		2-27-68				R.V. Houck, Jr.		Liberty Rd. Sykesville, Md.			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS				22f. LOCATION		Street or R.F.D. No.		City or Town County State	
R.V. Houck, Jr.		Liberty Rd. Sykesville, Md.									
23a. BURIAL CREMATION, (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		2/29/1968		Woodlawn		Baltimore				Md.	
24. FUNERAL DIRECTOR		ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Harry H. Armstrong		4204 Ridgewood Ave				DATE Feb 29 1968		James J. Jones			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) First Middle Last SADIE OLIVIA HAMPSHIRE						2a DATE OF DEATH Month Day Year 2 12 68			2b HOUR P 11:10 M		
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH Jan. 15, 1888		6 AGE (In years last birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.					
10 CITY OR TOWN OF DEATH Towson, Maryland		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med. Center				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 4507 Glen Arm Ave			
14 FATHER'S NAME First Middle Last Philip Boulden				15 MOTHER'S MAIDEN NAME First Middle Last Susanna R Collins							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Mr Lynwood F Hampshire				Address 2920 Chesley Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemomediastinum and left hemothorax											
DUE TO, OR AS A CONSEQUENCE OF (b) Ruptured dissection of thoracic aorta											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a I certify that (I) (this hospital) attended the deceased from 2/12 , 19 68 , to 2/12 , 19 68 , that (I) (we) last saw the deceased alive on 2/12 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE John E. Adams						DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED Feb. 13, 1968	
22d. PHYSICIAN'S NAME (Type) JOHN E. ADAMS, M.D.						22e. ADDRESS Greater Baltimore Medical Center					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 2/16/68		23c NAME OF CEMETERY OR CREMATORY Grace Methodist				23d LOCATION (City or Town) (County) (State) Black Rock Md			
24. FUNERAL DIRECTOR Leonard J Ruck Inc Baltimore, Maryland						25a. REC'D BY REGISTRAR DATE FEB 15 1968		25b REGISTRAR'S SIGNATURE Alvin J. Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 1/68

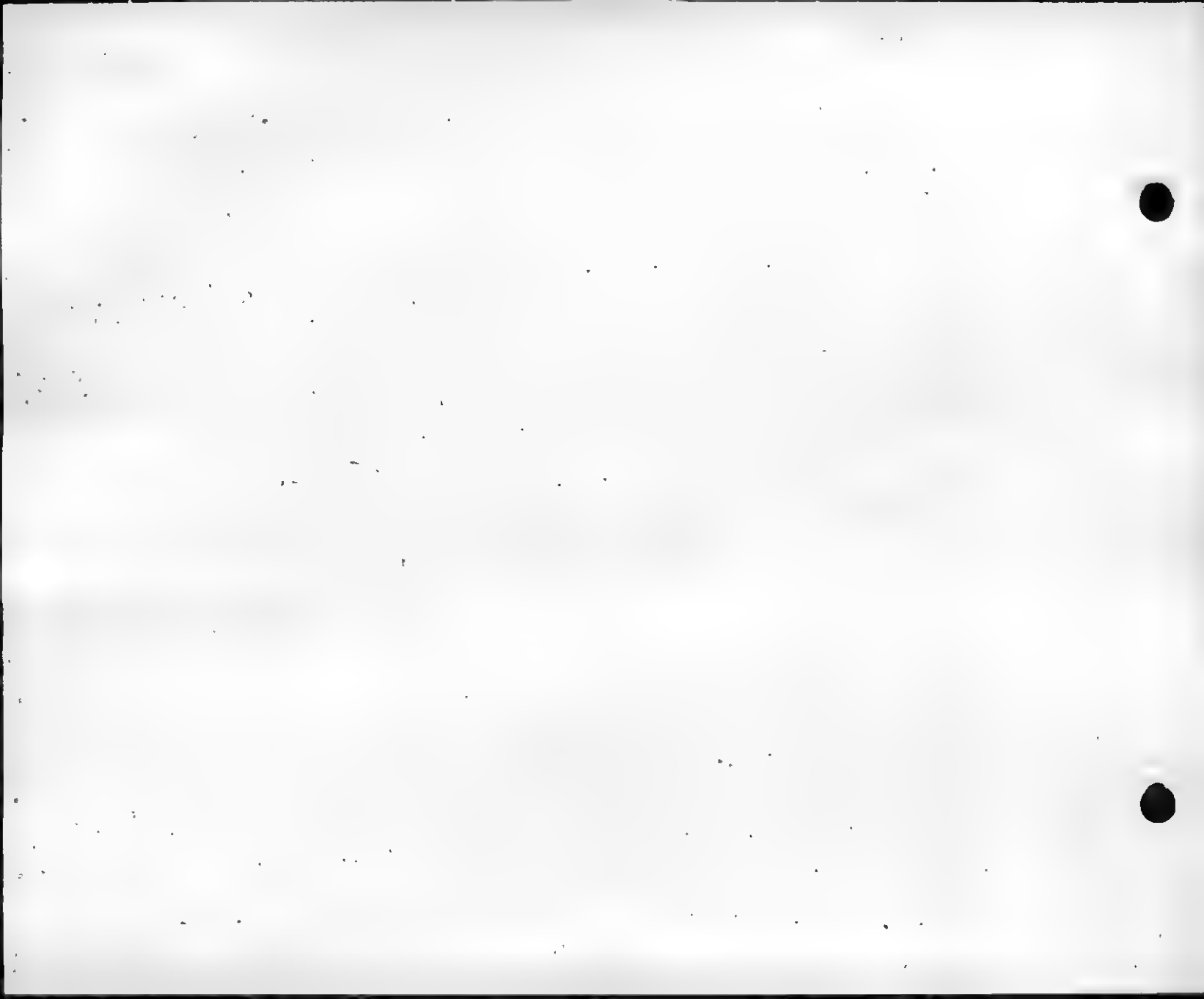
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02194

1. DECEASED-NAME (Type or print) First Middle Last Ira Isabelle Handwerker			2a. DATE OF DEATH Month Day Year February 5 1968			2b. HOUR M	
3 SEX Female		4. RACE White		5. DATE OF BIRTH January 30 1877		6. AGE (In years last birthday) YRS. 90	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md	
10. CITY OR TOWN OF DEATH Cockeysville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Md. Masonic Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md			13b. COUNTY -		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First Middle Last Valentine Cook			15. MOTHER'S MAIDEN NAME First Middle Last Martha Bailey				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 055-09-7102D		17. INFORMANT Address Records of Md Masonic Home Cockeysville Md			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery occlusion DUE TO, OR AS A CONSEQUENCE OF (b) Criminalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Marked Senility Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) 42.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from August 15, 1965, to Feb 5, 1968, that (I) (we) last saw the deceased alive on Feb 3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. 4-15 AM 2/5/68.							
22b. SIGNATURE JAMSHID HAMED MD.				22c. DATE SIGNED 2/5/68		22d. PHYSICIAN'S NAME (Type) JAMSHID HAMED MD.	
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE Feb. 6 1968		23c. NAME OF CEMETERY OR CREMATORY Herbrew Friendship		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD.	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson.				25a. REC'D BY REGISTRAR FEB 9 1968		25b. REGISTRAR'S SIGNATURE [Signature]	

12204



FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR

VR A15ME (5)
10M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) Cassander - HARDY			2a DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 2 29 1968			2b HOUR 5:30		
3 SEX Female	4 RACE Negro	5 DATE OF BIRTH 11/19/57	6 AGE (in years last birthday) 10 YRS	7 UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	8 UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	2c DATE PRONOUNCED DEAD Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 2 29 1968		
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore		
10 CITY OR TOWN OF DEATH Owings Mills		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rosewood State Hospital		12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired) Dependent		12b KIND OF BUSINESS OR INDUSTRY none		
13a USJA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b COUNTY Baltimore		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1335 East North Avenue
14 FATHER'S NAME First William Middle - Last Thomas			15 MOTHER'S MAIDEN NAME First Helen Middle Maxine Last Hardy					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b SOCIAL SECURITY NO. (If yes give war or dates of service) none		17. INFORMANT ADDRESS Rosewood Records, Owings Mills, Maryland				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Fractured Left Humerous DUE TO, OR AS A CONSEQUENCE OF (c) Epilepsy - Spastic Quadriplegia								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days 10 days ? Since three months of age
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a DATE OF OPERATION 2/19 1968		19b CONDITION FOR WHICH OPERATION WAS PERFORMED? Unknown				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH 1:30 PM 2/19 1968		21b TIME OF INJURY Month, Day, Year HOUR A.M. 1:30 PM 2/19 1968		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) Unknown				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street factory, office building, etc.) Wyse Cottage		21f LOCATION Street or R.F.D. No Rosewood St. Hosp., Owings Mills, Balto. Md. City or Town Baltimore County Baltimore State Md.				
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE D. D. Caples		EXAMINER'S NAME (Type) D. D. Caples, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MED. CA. EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED 3/4/68		
23a ADDRESS J. F. Eline & Sons Reisterstown, Md.		23b DATE 3/6/68		23c NAME OF CEMETERY OR CREMATORY Rosewood Cemetery		23d LOCATION (City or Town) (County) (State) Owings Mills, Md.		
24 FUNERAL DIRECTOR J. F. Eline & Sons Reisterstown, Md.				25a REC'D BY REGISTRAR DATE MAR 8 1968		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Items 13 c & 13e Film 4397 2/19/68											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) Agnes Gertrude HARTMAIER						2a. DATE OF DEATH Month 2 Day 6 Year 68			2b. HOUR 6:00P		
3 SEX Female		4 RACE White		5. DATE OF BIRTH April 21, 1881		6 AGE (n years last birthday) 86 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Missouri		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County					
10. CITY OR TOWN OF DEATH Mount Wilson		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Mt. Wilson State Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USBA. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Balto		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 119 Swansea Rd. Stelle Marie's Hospice			
14. FATHER'S NAME First Middle Last Richard Hartmaier				15. MOTHER'S MAIDEN NAME First Middle Last Marie Diven							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) No		16b. SOCIAL SECURITY NO 490-16-5778		17. INFORMANT Address Records, Mt. Wilson State Hospital							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Rheumatic Heart Disease											
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Pulmonary Fibrosis and Emphysema associated with Tuberculosis											
19a. DATE OF OPERATION		19b. CONDIT ON FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from Jan. 25, 19 68 , to Feb. 6 19 68 , that (I) (we) last saw the deceased alive on Feb. 6 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE W. Newcomer						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.						22e. ADDRESS Mount Wilson, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 2/10/68		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.					
24. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Towson 1050 York Rd. 21204						25a. REC'D BY REGISTRAR DATE FEB 13 1968		25b. REGISTRAR'S SIGNATURE			

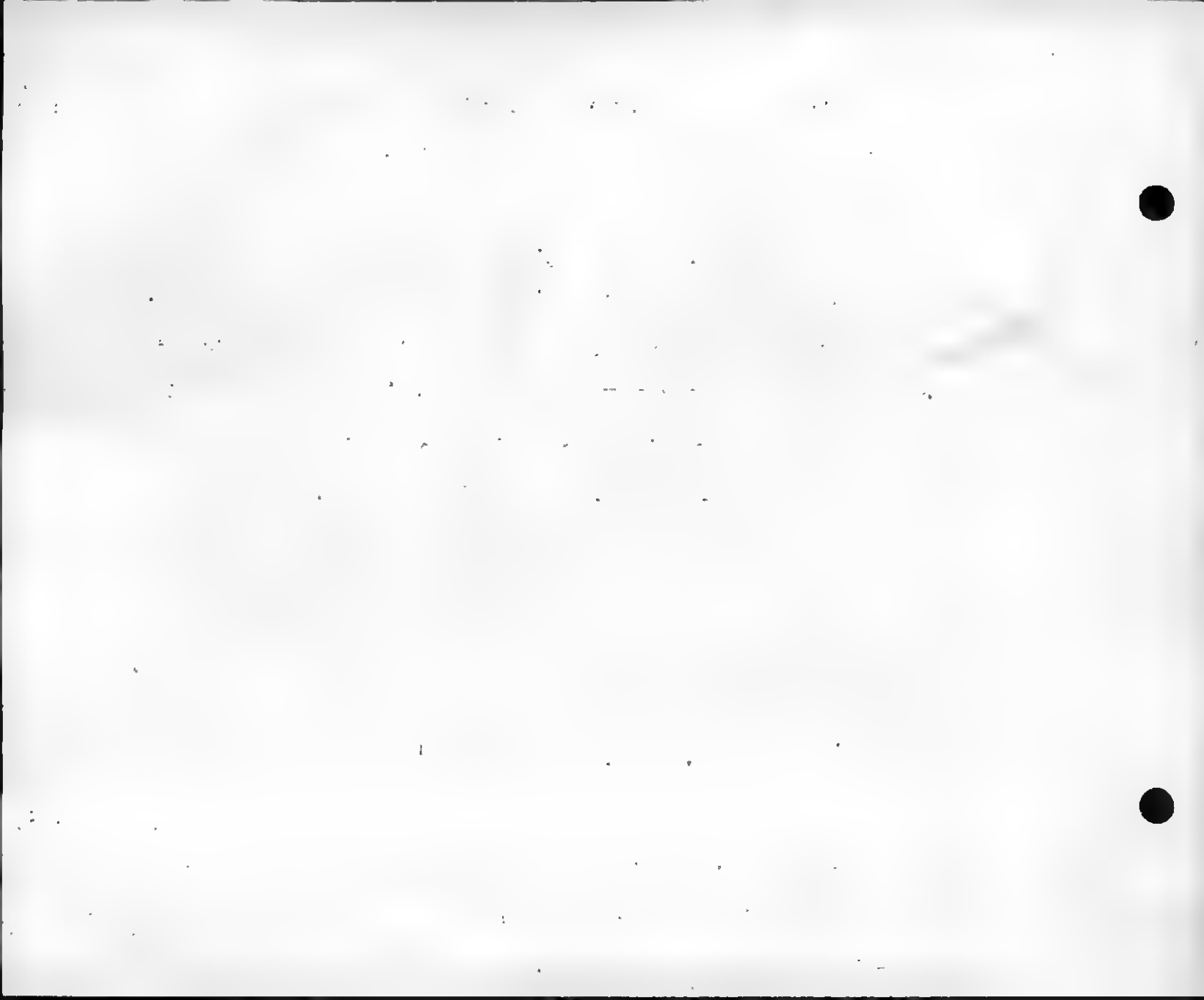


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VR A15 (4)
30M REV 1/68

<div style="display: flex; justify-content: space-between;"> 12207 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02195 </div>												
1. DECEASED-NAME (Type or print)			First FRANCES		Middle M.		Last HARTZELL		2a. DATE OF DEATH February ^{Month} 19 ^{Day} 1968		2b. HOUR 4:30 PM	
3. SEX Female			4. RACE White			5. DATE OF BIRTH October 7, 1903			6. AGE (In years last birthday) 64 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md.			
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if admission) STATE Md.			13b. COUNTY Baltimore			13c. CITY OR TOWN Towson			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 28 Dunvale Rd.	
14. FATHER'S NAME First Middle Last Francis X. Milholland						15. MOTHER'S MAIDEN NAME First Middle Last Mary Loretta Osing						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no			16b. SOCIAL SECURITY NO (If yes give war or dates of service) B-705-03-4795			17. INFORMANT Andrew C. Hartzell			Address 24 Dunvale Rd. #4			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia left lower lobe</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Massive intra-cerebral hemorrhage.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from February 15, 1968, to February 19, 1968, that (I) (we) last saw the deceased alive on February 19, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Lawrence F. Misanik</i>									22c. DATE SIGNED February 20, 1968			
22d. PHYSICIAN'S NAME (Type) Lawrence F. Misanik, M.D.						22e. ADDRESS 7620 York Rd., Towson, Md. 21204						
23a. BURIAL, CREMATION, REMOVAL (Specify) burial			23b. DATE 2/22/68		23c. NAME OF CEMETERY OR CREMATORY New Cathedral			23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland				
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home 6500 York Rd. Balto., Md. 21212						25a. REC'D BY REGISTRAR DATE FEB 26 1968			25b. REGISTRAR'S SIGNATURE			



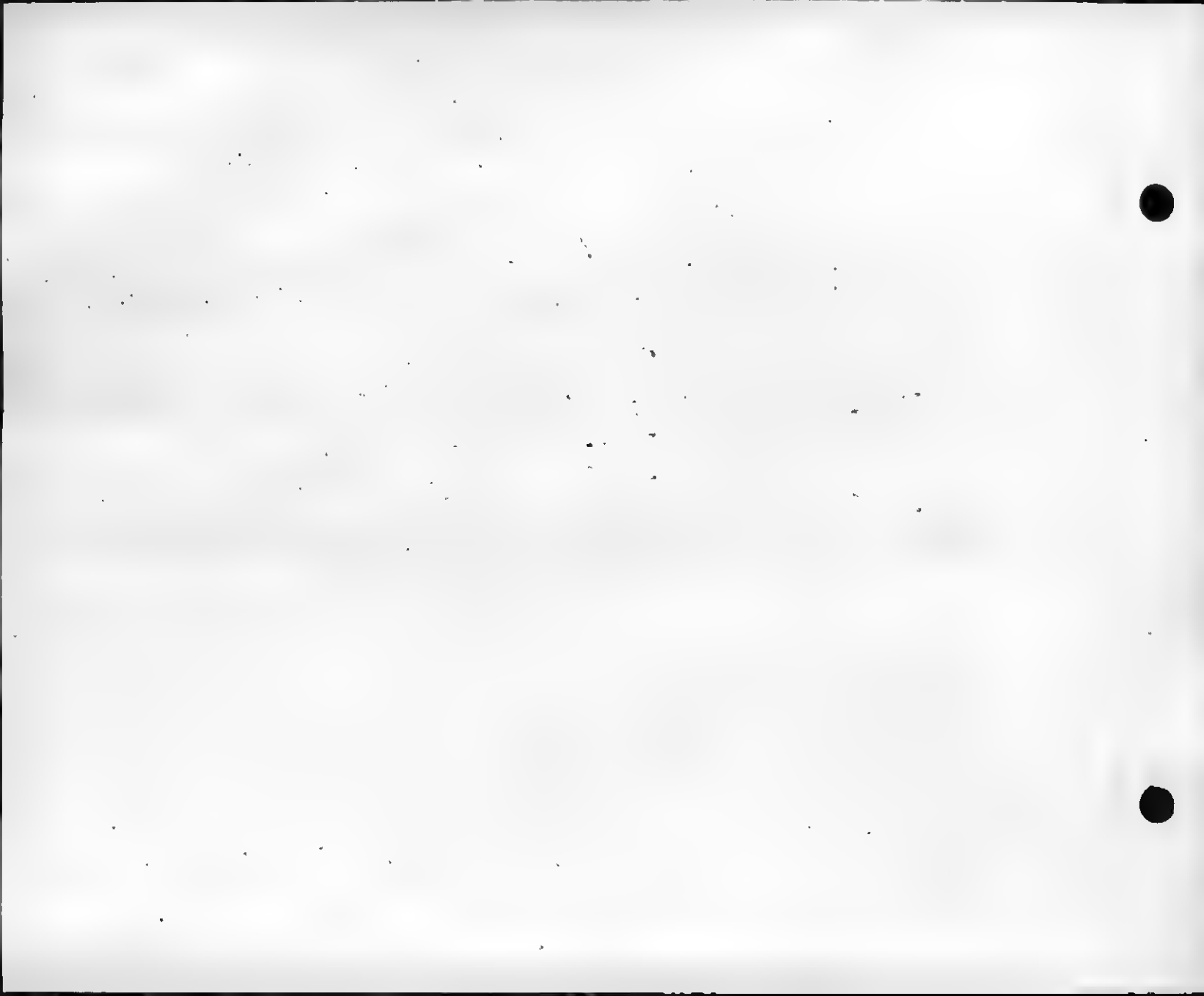
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62208
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

22136

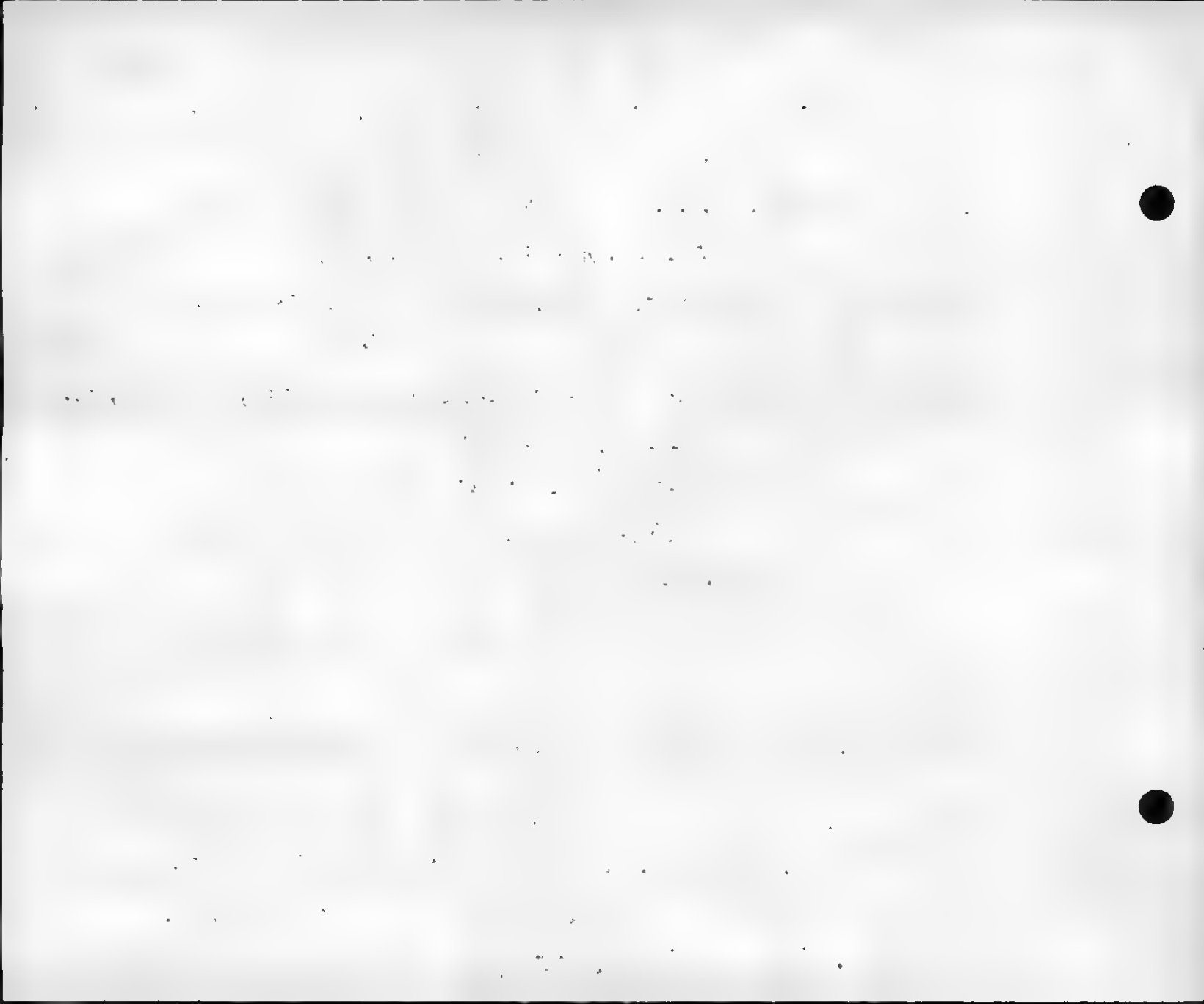
1. DECEASED NAME (Type or print) Theresa O. Hayner			2a. DATE OF DEATH Month 2 Day 3 Year 68			2b. HOUR 11 PM	
3 SEX Fem		4 RACE Caus		5. DATE OF BIRTH 7-21-1878		6. AGE (In years last birthday) 89 YRS.	
7a. BIRTHPLACE (State or foreign country) Poland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto.	
10 CITY OR TOWN OF DEATH Catonsville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1329 Middle Ford Rd.		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md		13b. COUNTY Balto.		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY (Y.N.T.S.P.) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 1329 Middle Ford Rd		14 FATHER'S NAME First ? Middle Olechnowicz Last ?		15. MOTHER'S MAIDEN NAME First ? Middle ? Last ?			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 094-16-8401		17 INFORMANT Mrs. David Pius		Address Sam	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 4120 DUE TO, OR AS A CONSEQUENCE OF: (b) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF: (c) Hypertensive Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 44							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 2-2 , 19 68 , to 2-3 , 19 68 , that (I) (we) last saw the deceased alive on 2-3 , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22a. SIGNATURE Domingo M.D. DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-3-68	
22d. PHYSICIAN'S NAME (Type) DOMINGO C. SORONGON M.D.				22b. ADDRESS 3915 HOLLINS FERRY RD. BALTIMORE, Md. 21227			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 2-4-1968		23c. NAME OF CEMETERY OR CREMATORY Lesczynski Fun. Home		23d. LOCATION (City or Town) (County) (State) Schenectady, N.Y.	
24. FUNERAL DIRECTOR Wm. Cook-Brooks, Inc. ADDRESS 12175 Paul St. Balto., Md. 21262				25a. REC'D BY REGISTRAR DATE FEB 6 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



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MARYLAND STATE DEPARTMENT OF HEALTH																		
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																		
CERTIFICATE OF DEATH																		
1. DECEASED NAME (Type or print)			First CHARLES			Middle D.			Last HEARD			2a. DATE OF DEATH Month 2 Day 26 Year 68			2b. HO. JR. 6:30A			
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 4/30/92			6. AGE (in years last birthday) 75 YRS.			IF UNDER 1 YEAR MONTHS 15 DAYS 15 HOURS 15 MIN.			IF UNDER 24 HRS HOURS 15 MIN.			
7a. BIRTH-PLACE (State or foreign country) ST. MARY'S COUNTY, MD.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE COUNTY, Md									
10. CITY OR TOWN OF DEATH FORT HOWARD			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. ADM. HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) LABORER			12b. KIND OF BUSINESS OR INDUSTRY STATE ROADS									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ANNE ARUNDEL			13c. CITY OR TOWN ANNAPOLIS			13d. INS. DE CITY, JAN 15? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER ROUTE 1, Box 622						
14. FATHER'S NAME First DENT Middle HEARD			15. MOTHER'S MAIDEN NAME First ANNA Middle CLARK															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) YES			16b. SOCIAL SECURITY NO 214 05 28 38			17. INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC DECOMPENSATION 4-17 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) PULMONARY HYPERTENSION (c) PULMONARY EMPHYSEMA													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) GENERALIZED ARTERIOSCLEROSIS																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)												
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State												
22a. I certify that (X) (this hospital) attended the deceased from 1/27/68 , 19 68 , to 2/26/68 , 19 68 , that (X) (we) last saw the deceased alive on 2/26/68 , 19 68 , and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (do) view the body after death.																		
22b. SIGNATURE John D. Talbert, M.D.													22c. DATE SIGNED 2/26/68					
22d. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.			22e. ADDRESS VAH FORT HOWARD, MARYLAND															
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 2-29-68			23c. NAME OF CEMETERY OR CREMATORY HILLCREST CEMETERY			23d. LOCATION (City or Town) (County) (State) ANNAPOLIS, MD.									
24. FUNERAL DIRECTOR John M. Taylor			ADDRESS TAYLOR FUNERAL HOME			25a. REC'D BY REGISTRAR DATE FEB 28 1968			25b. REGISTRAR'S SIGNATURE Charles Judge									



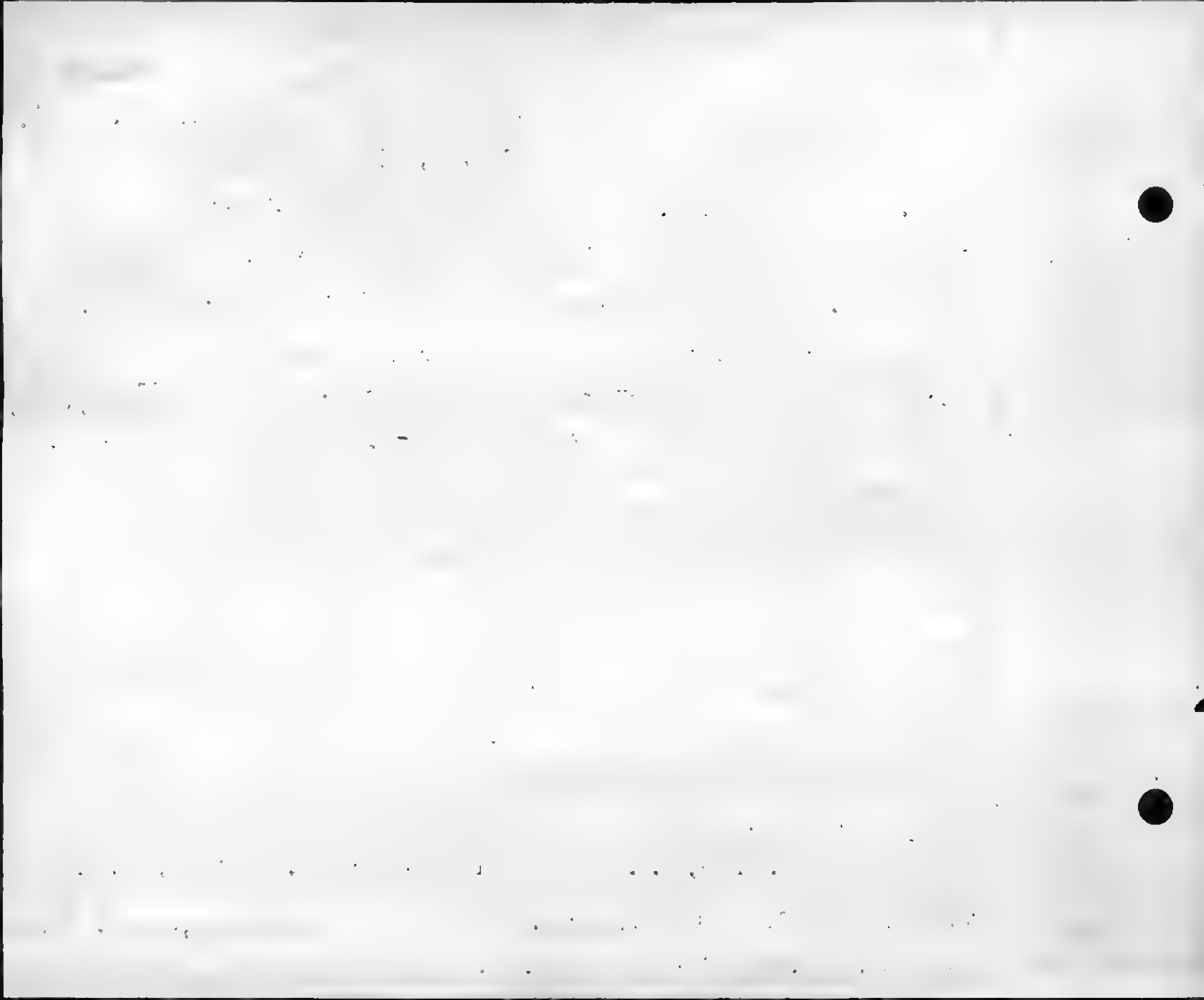
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VR 15 (4)
304 REV 1/68

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last William P. Heatterich			2a DATE OF DEATH Month Day Year Feb. 9, 1968			2b HOUR 12:30			
3 SEX Male		4 RACE White		5 DATE OF BIRTH Feb. 14, 1892		6 AGE (In years last birthday) 75		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN YRS.	
7a BIRTHPLACE (State or foreign country) Md.		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
10 CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Chesapeake Manor Nursing Home		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Nurse		12b KIND OF BUSINESS OR INDUSTRY Nurse			
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Md.		13b COUNTY Baltimore		13c CITY OR TOWN Rockdale		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 3000 Cordoned Rd.	
14 FATHER'S NAME First Middle Last Conrad Heatterich				15. MOTHER'S MAIDEN NAME First Middle Last Rosie Pfarr					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO. 214-01-5203		17. INFORMANT Mrs. Caroline L. Heatterich		Address 3000 Cordoned Rd.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. 4329 IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MONTHS									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 332X									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC		21f LOCATION Street or R.F.D. No. City or Town County State					
22a I certify that (I) (this hospital) attended the deceased from Dec 12, 1967, to Feb 9, 1968, that (I) (we) last saw the deceased alive on Feb 9, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Luis J. Elias						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2/10/68	
22d. PHYSICIAN'S NAME (Type) Luis J. Elias, M.D.				22e. ADDRESS 1701 Meridene Dr. Baltimore, Md. 21212					
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-12-1968		23c NAME OF CEMETERY OR CREMATORY Woodlawn		23d LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR G. Howard Strong				ADDRESS 3207 W. North Ave.,		25a REC'D BY REGISTRAR DATE FEB 13 1968		25b REGISTRAR'S SIGNATURE	

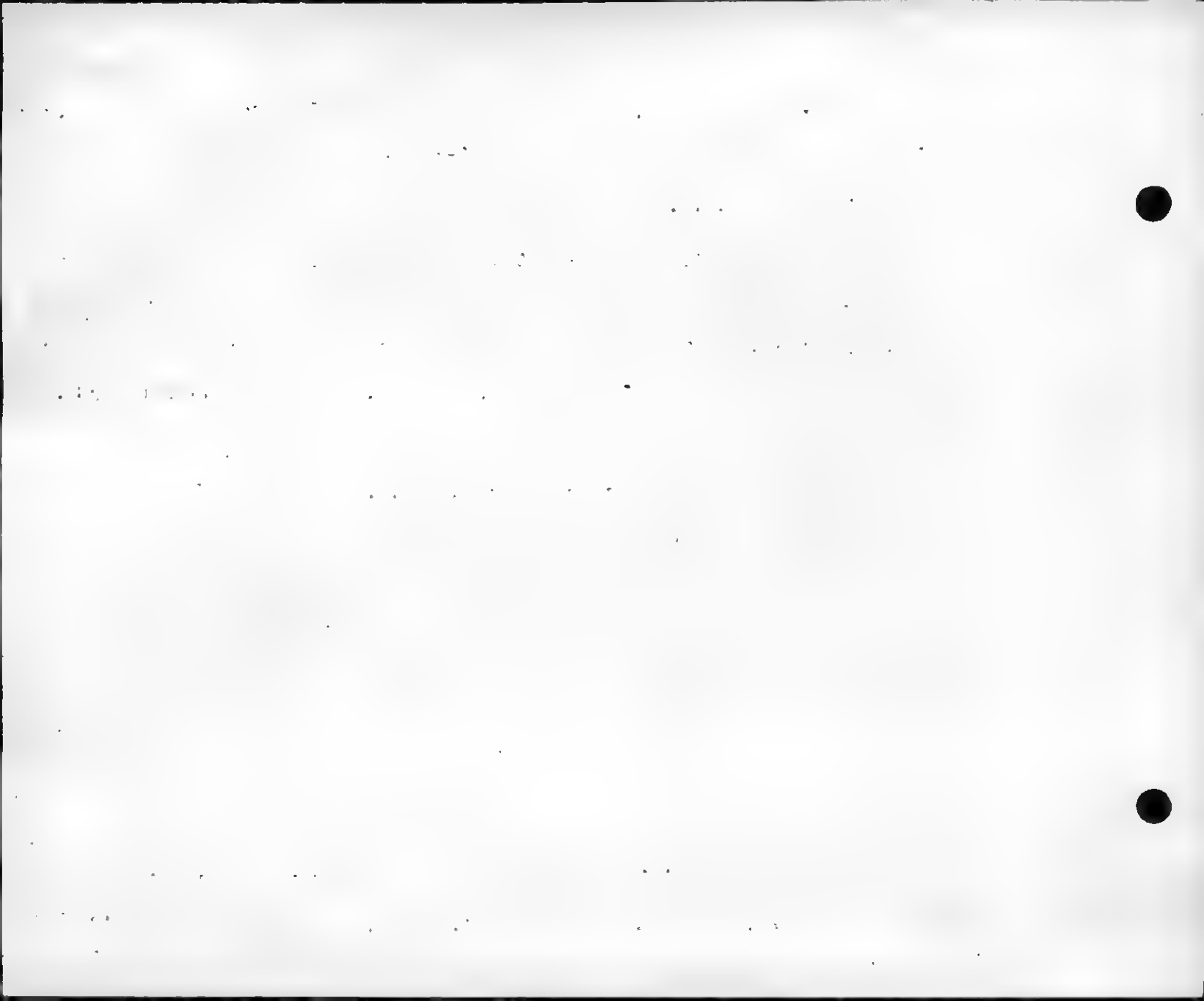


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VR A15 (4)
30M REV 1/68

<div style="text-align: center;"> <div>02211</div> <div>02194</div> </div> <div style="text-align: center;"> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> </div>													
1. DECEASED NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH			2b. HOUR	
			Carl		E.		Hensley		February Month Day Year 17 68			5.40 PM	
3 SEX		4. RACE		5. DATE OF BIRTH				6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
Male		White		10-27-1897				70 YRS					
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Virginia			U.S.A.						Baltimore Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Towson			St. Joseph Hospital			FARM LABOR			FARMING				
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Md.			BALTIMORE			Phoenix				Jarrettsville Pike			
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME								
First Middle Last					First Middle Last								
ELLSWORTH THOMAS HENSLEY					MARY EMMA BREEDEN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					16b. SOCIAL SECURITY NO		17. INFORMANT					Address	
No					220/09/7636		MRS. MARY M. HENSLEY					PHOENIX, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia													
773.2 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost													
(b) Chronic renal disease, C.H.F.													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 2/11, 1968, to 2/17, 1968, that (I) (we) last saw the deceased alive on 2/17, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Alexis S. Sayoc M.D.								DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 2-17-68	
22d. PHYSICIAN'S NAME (Type) Alexis Sayoc M.D.								22e. ADDRESS 7620 York Rd. Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)		(County)		(State)	
BURIAL			2/20/68		MT. OLIVET PRES. CEME.			RED HANCOCK		WASH., MD.			
24. FUNERAL DIRECTOR								ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Howard J. Shore Hancock Md										FEB 23 1968			



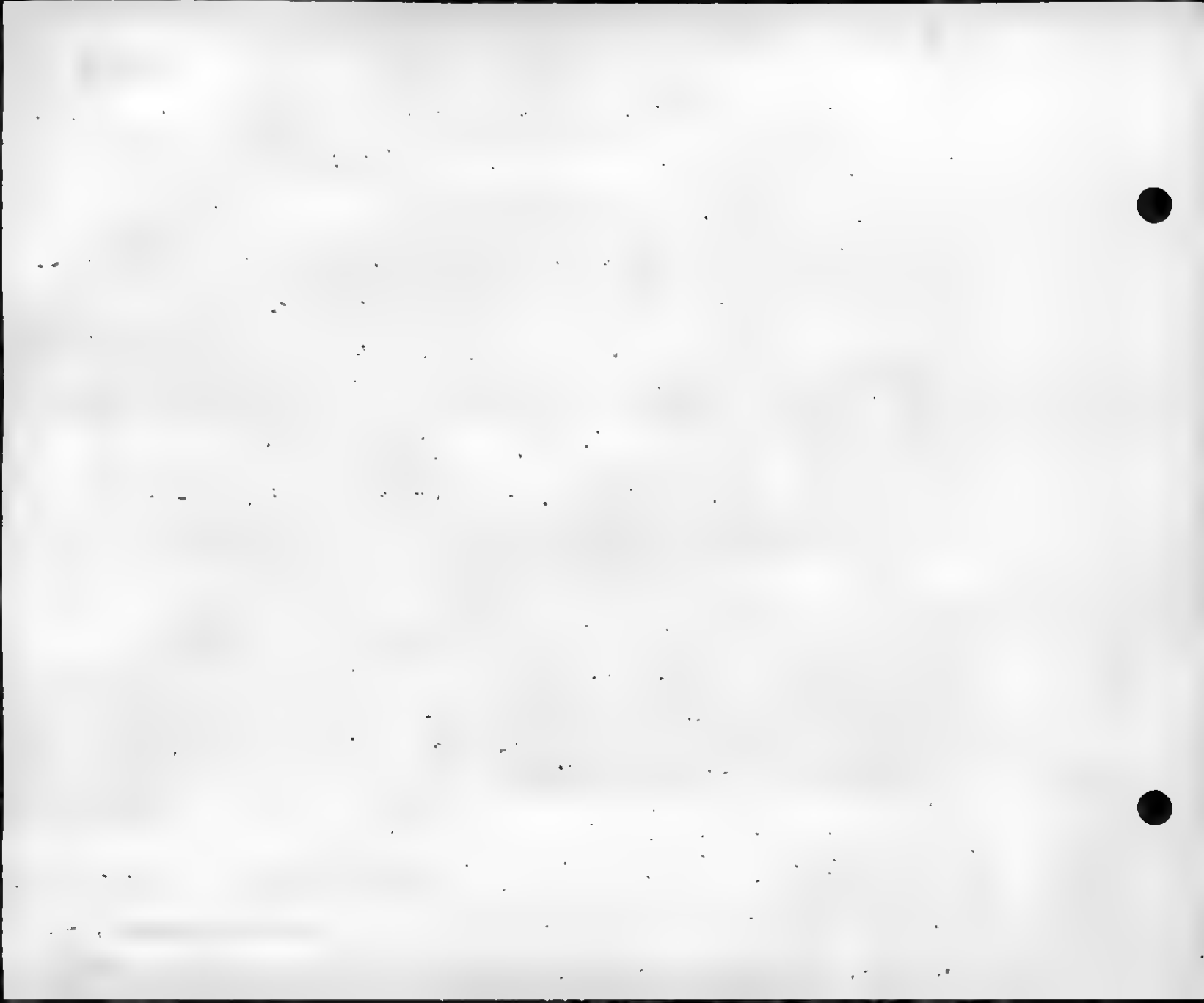
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) First Middle Last DESSIE GERTRUDE HERRING						2a. DATE OF DEATH Month Feb Day 7 Year 1968			2b. HOUR 8:30 PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH Aug 31, 1887		6. AGE (In years last birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.					
10. CITY OR TOWN OF DEATH Freeland		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Middletown Rd				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) House wife			12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Freeland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Middletown Rd.			
14. FATHER'S NAME First Middle Last George Kyger				15. MOTHER'S MAIDEN NAME First Middle Last Louise BAUGHER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO 225-01-4313		17. INFORMANT Address Mrs Floyd LAM. Freeland Md							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from JAN. 2, 1952 to Feb 7, 1968 , that (I) (we) last saw the deceased alive on Feb 5, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Joseph E. T. Bush DEGREE						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Feb 7 1968			
22d. PHYSICIAN'S NAME (Type) Joseph E. T. Bush M.D.						22e. ADDRESS WAMPSTEAD Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-10-1968		23c. NAME OF CEMETERY OR CREMATORY Gunpowder Baptist		23d. LOCATION (City or Town) (County) (State) Freeland, Baltimore, Md.					
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md.						25a. REC'D BY REGISTRAR DATE FEB 13 1968		25b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

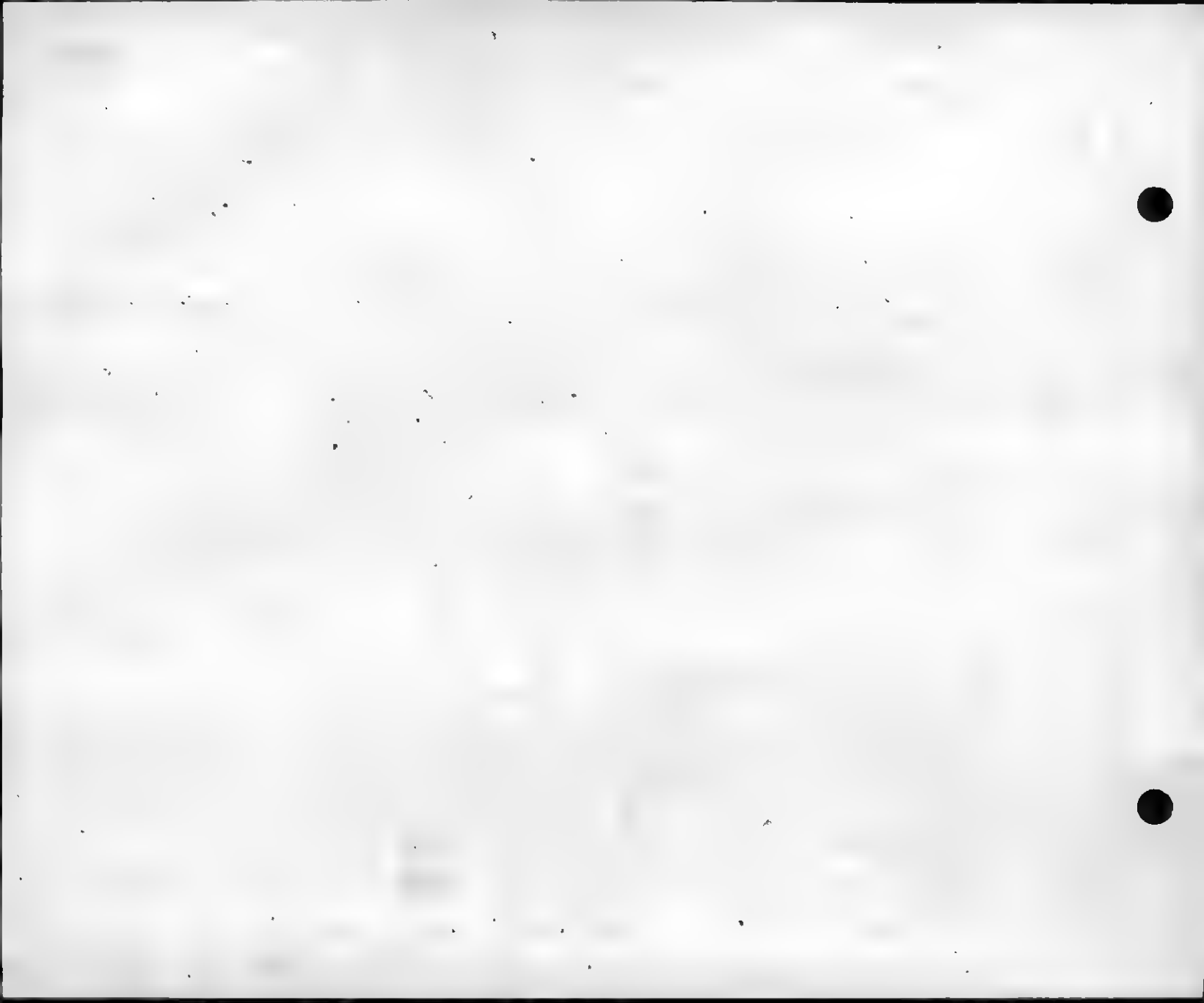


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR				
Gertrude M. HeHinger						Month 2 Day 5 Year 68			130 PM				
3 SEX		4 RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Female		White		2-16-84			83 YRS.		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Austria			U.S.A.						Baltimore, Md.			Md	
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore, Md.			Foxgloves Convalescent										
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER	
418 E. 26th St.			Baltimore			Maryland						418 E. 26th St.	
14 FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last										
Tasch, George			Frombach, Margaret										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address							
			30-000847-840			John C HeHinger - 418 E. 26th St							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Myocardial Infarction										Minutes			
Arteriosclerosis										Centuries			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State							
22a I certify that (I) (this hospital) attended the deceased from 1-20, 1968, to Feb 5, 1968, that (I) (we) last saw the deceased alive on 2-4, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (aid) (did not) view the body after death													
22b SIGNATURE David J. Miller M.D. DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									22c DATE SIGNED 2-5-68				
22d PHYSICIAN'S NAME (Type) David J. Miller M.D.									22e ADDRESS 2150 R. 1000 Cambridge, Md				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			2-8-68		Moreland Memorial			Baltimore, Md					
24 FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR DATE			25b. REGISTRAR'S SIGNATURE				
Elboworth Armbrast-4600 Liberty Heights Ave						FEB 6 1968			Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

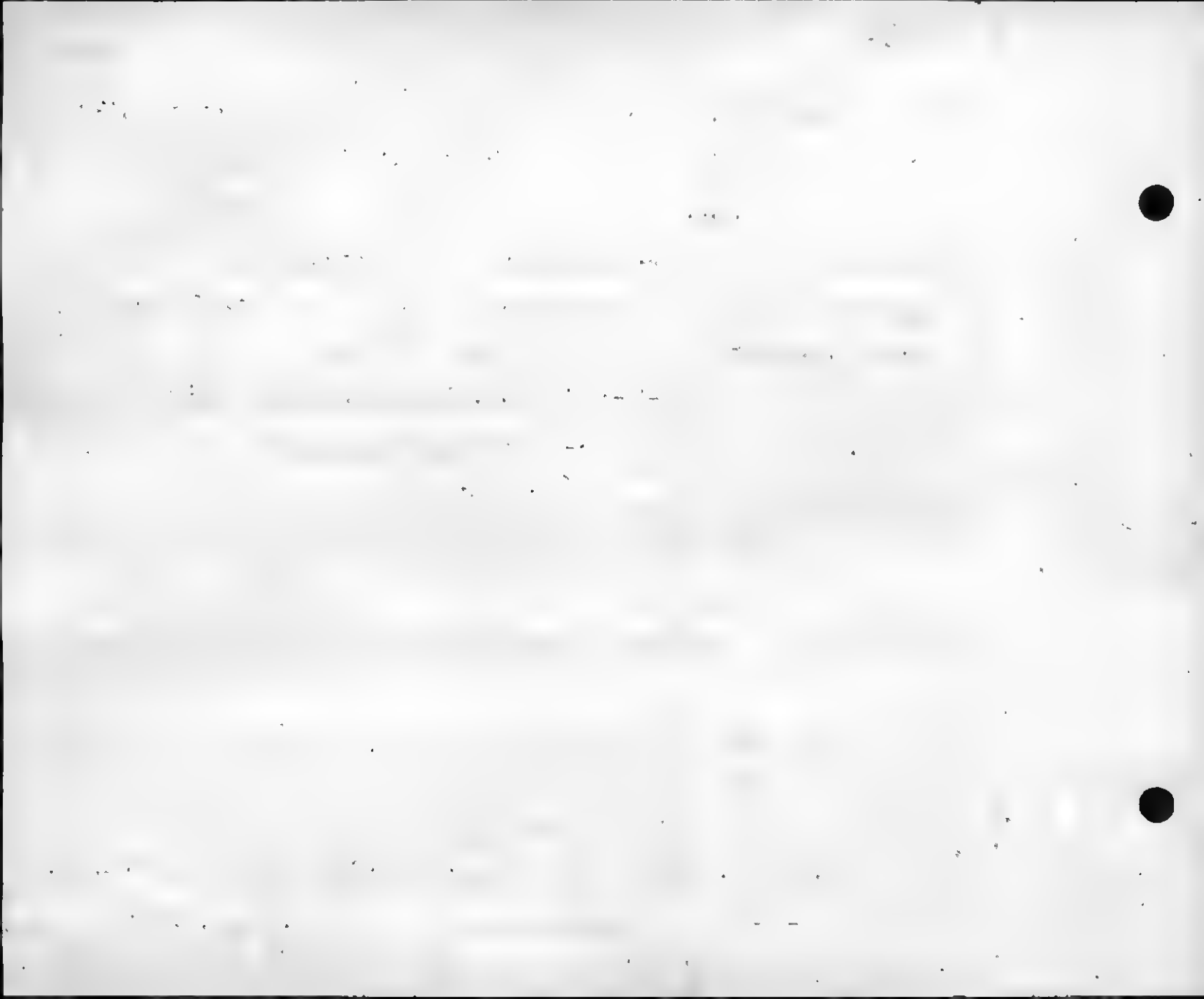
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VR A15 (4)
30th REV. 1/68

22214
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

22202

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR	
ELLA G. HICKCOX					February 17, 1968		M	
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)	7 IF UNDER 1 YEAR		8 IF UNDER 24 HRS.
Female	White		January 7, 1875		93 YRS	MONTHS DAYS		HOURS MIN
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Ohio	U.S.A.				Baltimore		Md	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Towson		Chesapeake Manor		Homemaker				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER		
Maryland				Baltimore		1514 Waverly Way		
14. FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last					
George W. Gichhorn			Rachel Doubrava					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO		17 INFORMANT		Address		
No		213-10-6508 D		Mrs. Estelle M. Thomas		Same		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS								MONTHS
DUE TO, OR AS A CONSEQUENCE OF PNEUMONIA								DAYS
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from July 1st 1965, to FEB 16, 1968, that (I) (we) last saw the deceased alive on FEB 16 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.								
22b SIGNATURE				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE-SIGNED FEB 19/68
22d. PHYSICIAN'S NAME (Type)				22e ADDRESS				
Dr. Luis J. Elias				1701 Meredene Drive		Baltimore, Md.		
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Burial		2-20-68		Lorraine		Baltimore, Maryland		
24 FUNERAL DIRECTOR				ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE
Mitchell-Wiedefeld Home, Inc.				6500 York Rd. Baltimore, Md. 21212		FEB 21 1968		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

22215

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12203

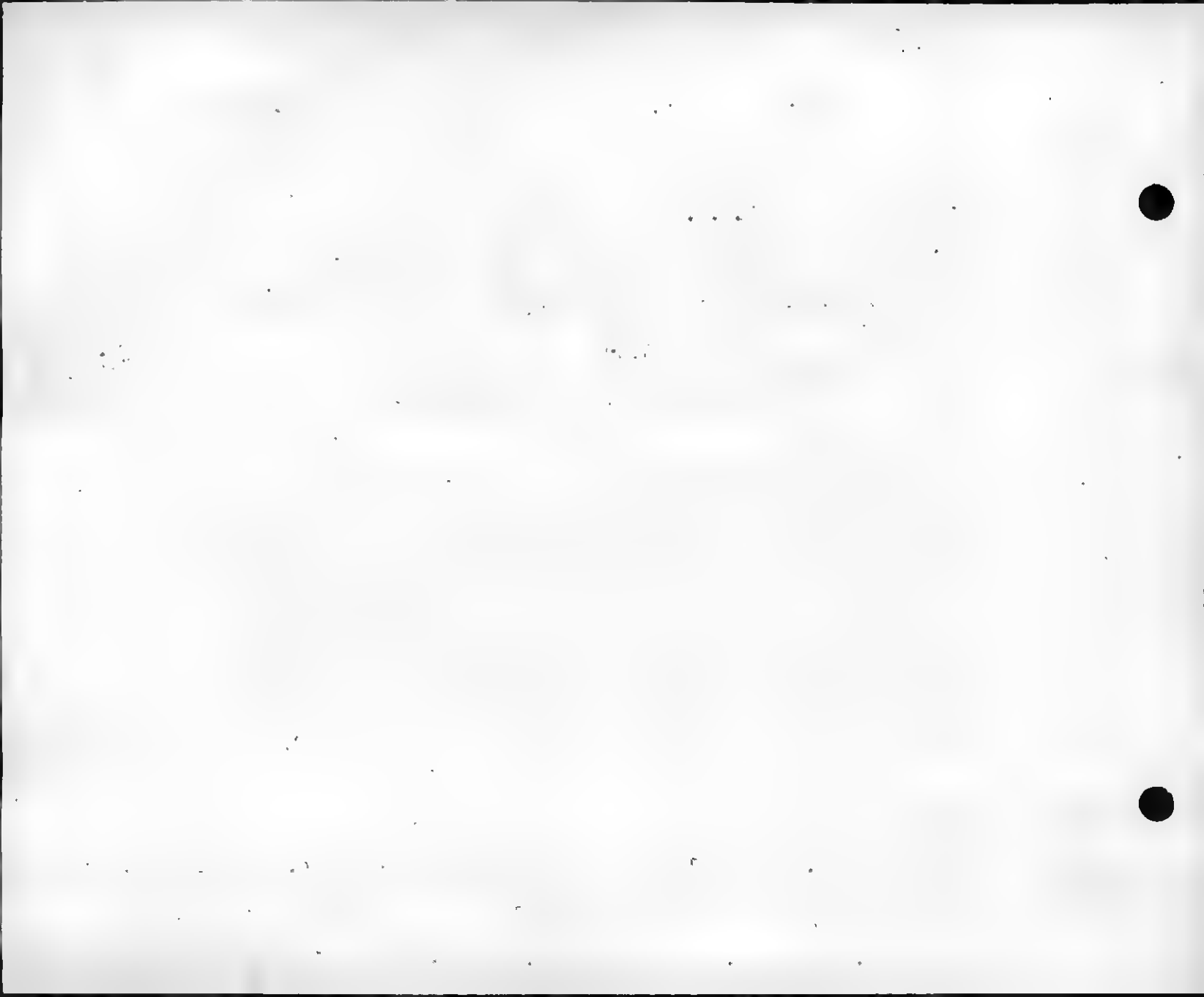
1. DECEASED-NAME (Type or Print) CHARLES			First Middle Last			2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year FEB. 12 1968			2b. HOUR M				
3 SEX M	4 RACE W	5 DATE OF BIRTH FEB. 16 1891	6 AGE (In years last birthday) 76 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS Min		F UNDER 24 HRS		2c. DATE PRONOUNCED DEAD Month Day Year FEB 12 1968			2d. HOUR M		
7a. BIRTHPLACE (State or foreign country) FLORIDA		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTO							
10 CITY OR TOWN OF DEATH BALTO MD			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 94 POPLAR RD			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) GARDENER			12b. KIND OF BUSINESS OR INDUSTRY BALTO CITY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD			13b. COUNTY BALTO			13c. CITY OR TOWN ESSEX			3c. INSIDE CITY <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			13e. STREET AND NUMBER 94 POPLAR RD	
14. FATHER'S NAME First Middle Last UNKNOWN						15. MOTHER'S MAIDEN NAME First Middle Last UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO 218-10-4959			17. INFORMANT HILMA M. HILL			ADDRESS 94 POPLAR RD.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ACVD												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Theo C. Patterson M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 2/13/68				
EXAMINER'S NAME (Type) THEO. C. PATTERSON						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 2/15/68			23c. NAME OF CEMETERY OR CREMATORY LONDON PARK CEM			23d. LOCATION (City or Town) (County) (State) BALTO MD				
24. FUNERAL DIRECTOR WEBER FUNERAL HOME						ADDRESS 531 EDWARDS AVE			25a. REC'D BY REGISTRAR 6 13 1968			25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) First Middle Last Mildred A. Hiltz						2a. DATE OF DEATH Month Day Year February 3 1968			2b. HOUR M 			
3. SEX Female		4. RACE White		5. DATE OF BIRTH March 20, 1896			6. AGE (In years last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN 	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.						
10. CITY OR TOWN OF DEATH Woodstock			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Davis Avenue			12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY 			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Woodstock		13d. INSIDE CITY LIM. 157 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Davis Ave				
14. FATHER'S NAME First Middle Last John Albert				15. MOTHER'S MAIDEN NAME First Middle Last Anna T. Mulhern								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No				16b. SOCIAL SECURITY NO. 		17. INFORMANT Address James E. Hiltz Same						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD. DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate 4 hrs.		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 												
19a. DATE OF OPERATION 		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) 		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) 								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) 		21f. LOCATION Street or R.F.D. No. City or Town County State 								
22a. I certify that (I) (this hospital) attended the deceased from 2/3 , 1968, to 2/3 , 1968; that (I) (we) lost the deceased on 2/3 , 1968, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE [Signature]						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2/3/68				
22d. PHYSICIAN'S NAME (Type) Dr. Morton Ellin						22e. ADDRESS 8629 Liberty Rd. Randallstown, Md						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/6/68		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City or Town) (County) (State) Baltimore Maryland						
24. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. 5305 Harford Rd. Balto						25a. REC'D BY REGISTRAR DATE 5 1968		25b. REGISTRAR'S SIGNATURE [Signature]				

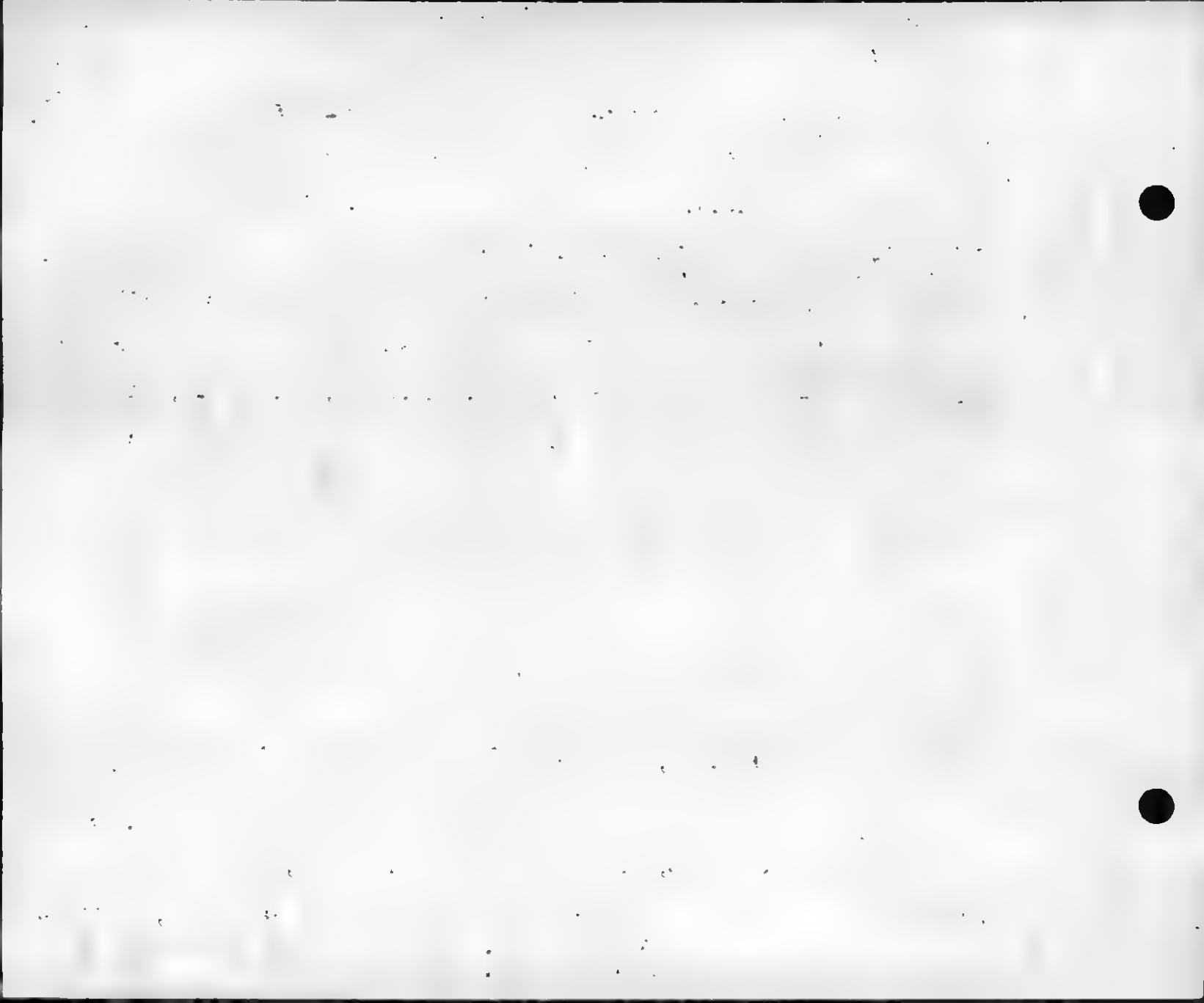


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

<div style="text-align: center;"> <p>22217</p> <p>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</p> <p>CERTIFICATE OF DEATH</p> <p style="text-align: right;">2205</p> </div>												
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR			
LESLIE			CORNELIUS			HINES			2 23 68 Month Day Year			4:30 P. M.
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR MONTHS DAYS
MALE			NEGRO			9 4 06			61 YRS			IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			12b. KIND OF BUSINESS OR INDUSTRY
WEST INDIES			U.S.A.						BALTIMORE			OIL CO.
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp to give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
FORT HOWARD			VETERANS ADM. HOSPITAL			LABORER						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER
MARYLAND			ANNE ARUNDEL			BALTIMORE						332 SNOW HILL ROAD
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
First Middle Last			First Middle Last									
JAMES			HINES			AMANDA			DASKENS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address			
YES			WW-11			218 10 54 05 CLIN. REC., VAH, FT. HOWARD, MARYLAND						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE											2 MONTHS	
DUE TO, OR AS A CONSEQUENCE OF (b)												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
PNEUMONIA												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec. 8, 1967, to Feb. 23, 1968, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Feb. 23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Ralph M. Howard, M.D.</i> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>									22c. DATE SIGNED 2 24 68			
22d. PHYSICIAN'S NAME (Type) RALPH M. HOWARD, M. D.									22e. ADDRESS VAH, FT. HOWARD, MARYLAND			
23a. BURIAL CREMATION, (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
BURIAL						BALTIMORE NATIONAL CEMETERY			BALTIMORE, MARYLAND			
24. FUNERAL DIRECTOR			1701 Laurens Ave.			25a. REC'D BY REGISTRAR DATE FEB 27 1968			25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			
Morton & Dyett Funeral Home, Baltimore, Md.												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30A REV 1/68

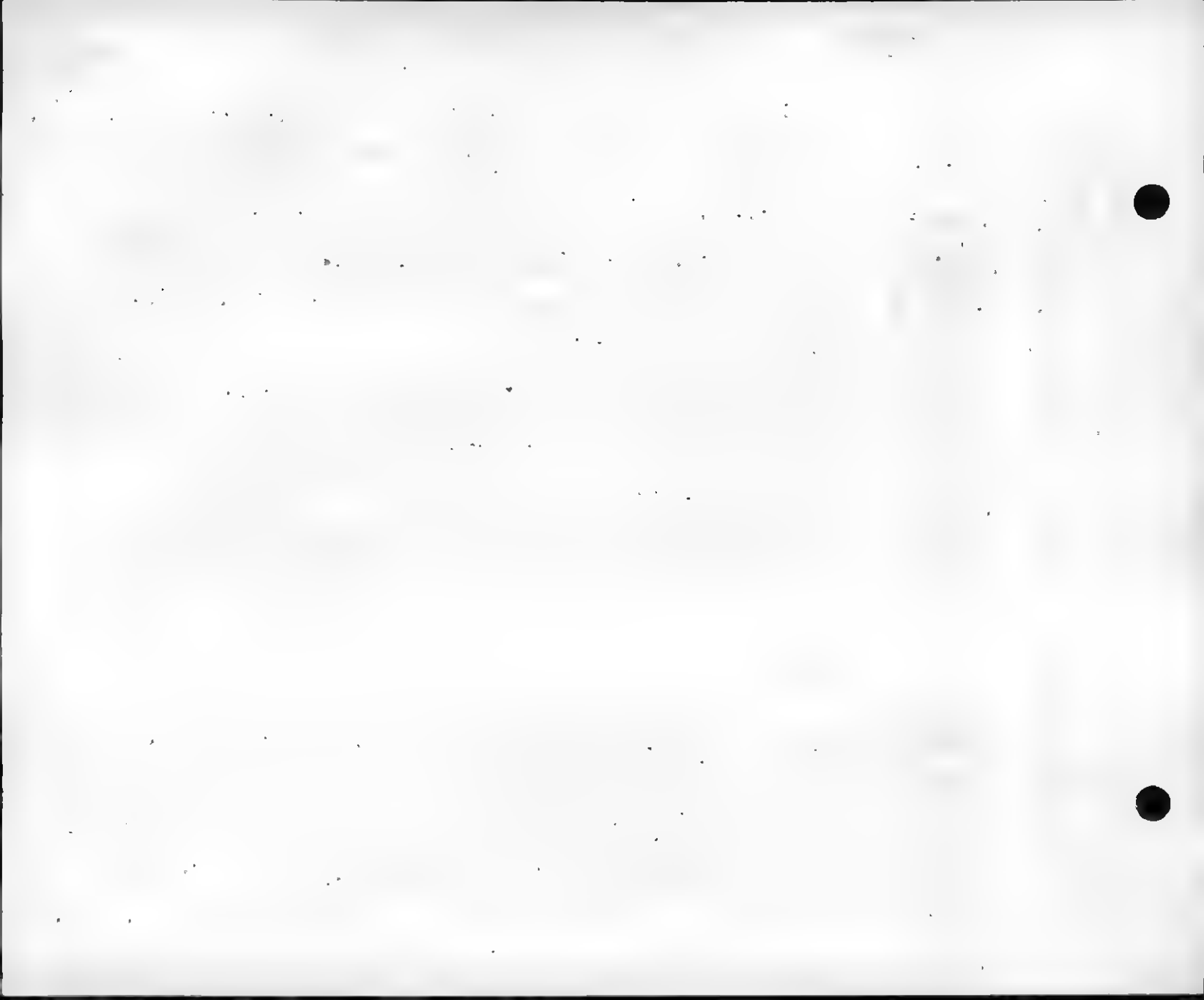
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02206

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR p. m.	
Carrie					HOFFMAN	February 8, 1968			4:25 p.	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. UNDER 1 YEAR MONTHS DAYS	
Female		White		April 22, 1885			82			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland			U.S.A.				Baltimore Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Towson			ST. JOSEPH HOSPITAL			Homemaker				
13a. USUAL RESIDENCE (Where deceased admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3e. STREET AND NUMBER	
Maryland					Baltimore				2712 Berwick Ave.	
4. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle
George					Ehrhardt	Mary				Carey
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address		
No			220-L-5275		Mr Philip Spies			5613 Laurelton Avenue		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive recurrent myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>coronary thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION		Street or R.F.D. No.		City or Town	County
										State
22a. I certify that (I) (this hospital) attended the deceased from <u>12/25/</u> , 19 <u>67</u> , to <u>2/8/</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2/8/</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE 						DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED February 9, 1968
22d. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.						22e. ADDRESS 7620 York Rd., Towson, Md. 21204				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)		(County)	(State)
Burial		2-12-1968		Parkwood Cemetery			Baltimore		Co.	Md.
24. FUNERAL DIRECTOR <u>Laurelton Funeral Home 2701 Belair Rd.</u>						ADDRESS		25a. REC'D BY REGISTRAR DATE FEB 13 1968		25b. REGISTRAR'S SIGNATURE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First Middle Last Daniel Bernard Hoffman			2a DATE OF DEATH Month Day Year Feb. 21 1968			2b HOUR 1.p.m.		
3 SEX Male		4 RACE White		5. DATE OF BIRTH June 3, 1892			6 AGE (In years lost birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.					
10 CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Baltimore Med. Cent.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farmer			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b COUNTY Washington		13c CITY OR TOWN Smithsburg		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
14 FATHER'S NAME First Middle Last John W. Hoffman				15 MOTHER'S MAIDEN NAME First Middle Last Emma Rowe							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) no			16b. SOCIAL SECURITY NO 220-30-9596A		17 INFORMANT Mr. Roger E. Rowe			Address Smithsburg #3, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Widespread metastatic CA of mouth 1457 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH July 1966	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) !											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that he (this hospital) attended the deceased from Feb. 7 , 19 68 , to Feb. 21 19 68 , that we (we) lost saw the deceased alive on Feb. 20 19 68 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, he (we) (did) (did not) view the body after death.											
22b SIGNATURE M. Estell Connolly						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c DATE SIGNED Feb. 21, 1968			
22d. PHYSICIAN'S NAME (Type)						22e ADDRESS					
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE 2/24/1968		23c NAME OF CEMETERY OR CREMATORY Green Hill		23d. LOCATION (City or Town) (County) (State) Waynesboro, Franklin, Penna.					
24. FUNERAL DIRECTOR Walter J. Grose						ADDRESS Waynesboro, Penna		25a REC'D BY REGISTRAR DATE FEB 26 1968		25b. REGISTRAR'S SIGNATURE Frederick J. Judge	

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1. The first group of variables includes the following:

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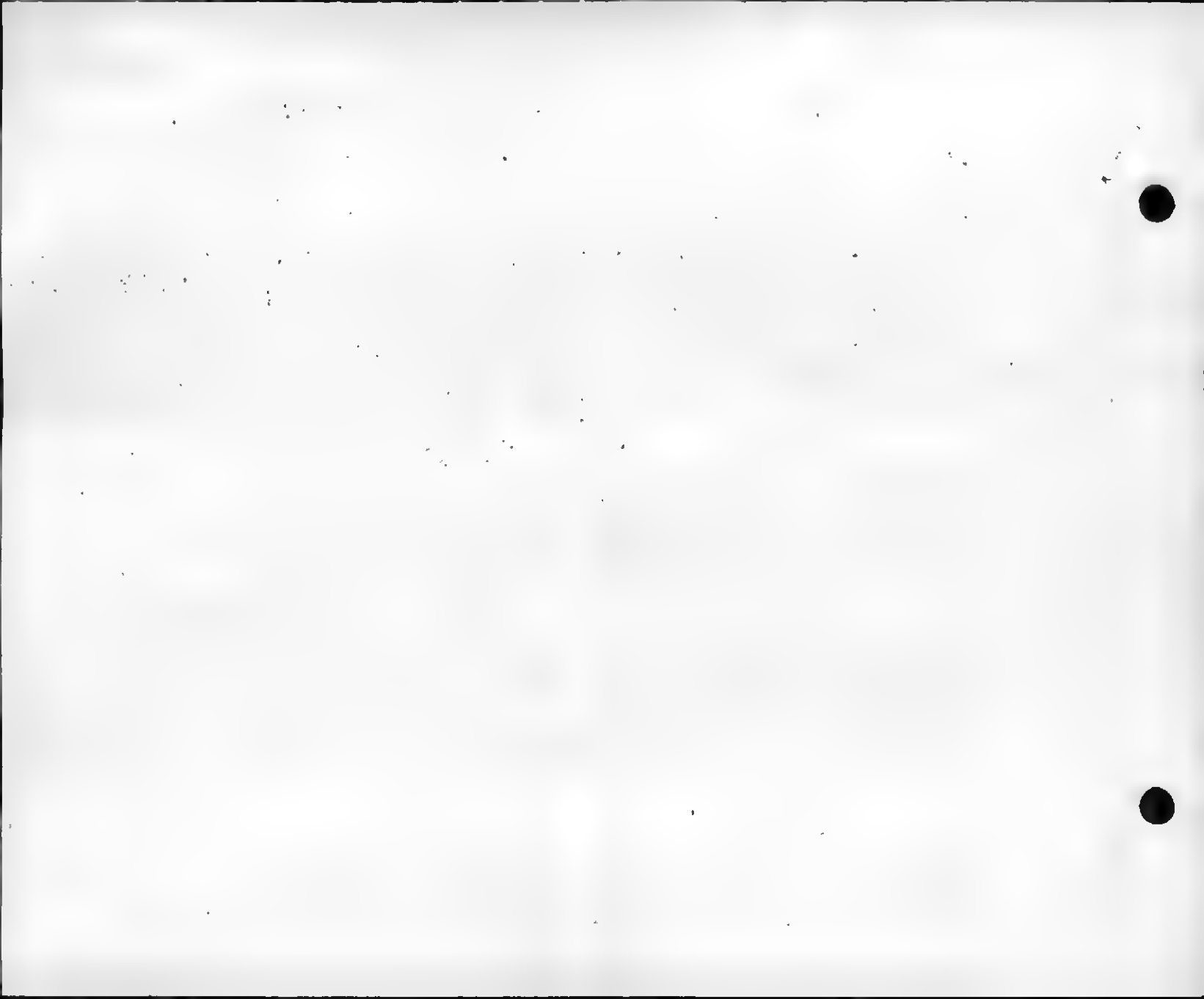
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

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VR A15 (4)
30M REV 1/68

| M | | | | | | | | | | |
|---|--|--|---|---|---|--|--|-----------------------------------|---|--|
| 32220 | | | | | | | | | | |
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 12208 | | | | | | | | | | |
| 1 DECEASED NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| EMANUEL | | | HOLLANDER | | | FEBRUARY 23, 1968 | | 1 30 AM | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (In years last birthday) | | IF UNDER 1 YEAR | | |
| MALE | | WHITE | | FEBRUARY 24, 1889 | | 78 YRS | | MONTHS DAYS HOURS MIN | | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | Md | | |
| NEW YORK CITY | | U.S.A. | | | | BALTIMORE | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| PIKESVILLE | | | MILFORD MANOR NURSING HOME | | | EXECUTIVE | | RETIRED IMPORTER | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | |
| MARYLAND | | | BALTIMORE | | PIKESVILLE | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | MILFORD MILL RD. MILFORD MANOR NURSING HOME | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | |
| DAVID | | | HOLLANDER | | | ANNA ? | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | #8 | |
| | | | | | MR. MORTON J. HOLLANDER | | 7941 LONG MEADOW ROAD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE | | | | | | | | | | |
| 4129 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (b) CARDIAC ARREST. | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 330 STORES-ADAMS-SYNDROME 3 yr | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | | |
| White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/11, 1968, to 2/23, 1968, that (I) (we) last saw the deceased alive on 2/23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | | | | |
| Joseph S. Blum | | 2/23/68 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | | |
| JOSEPH S. BLUM | | 1115 N. CALVERT STREET | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) (State) | | |
| BURIAL | | 2-26-68 | | UNION FIELD | | LONG ISLAND, NEW YORK | | | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | |
| SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | DATE FEB 26 1968 | | Charles Judge | | | | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

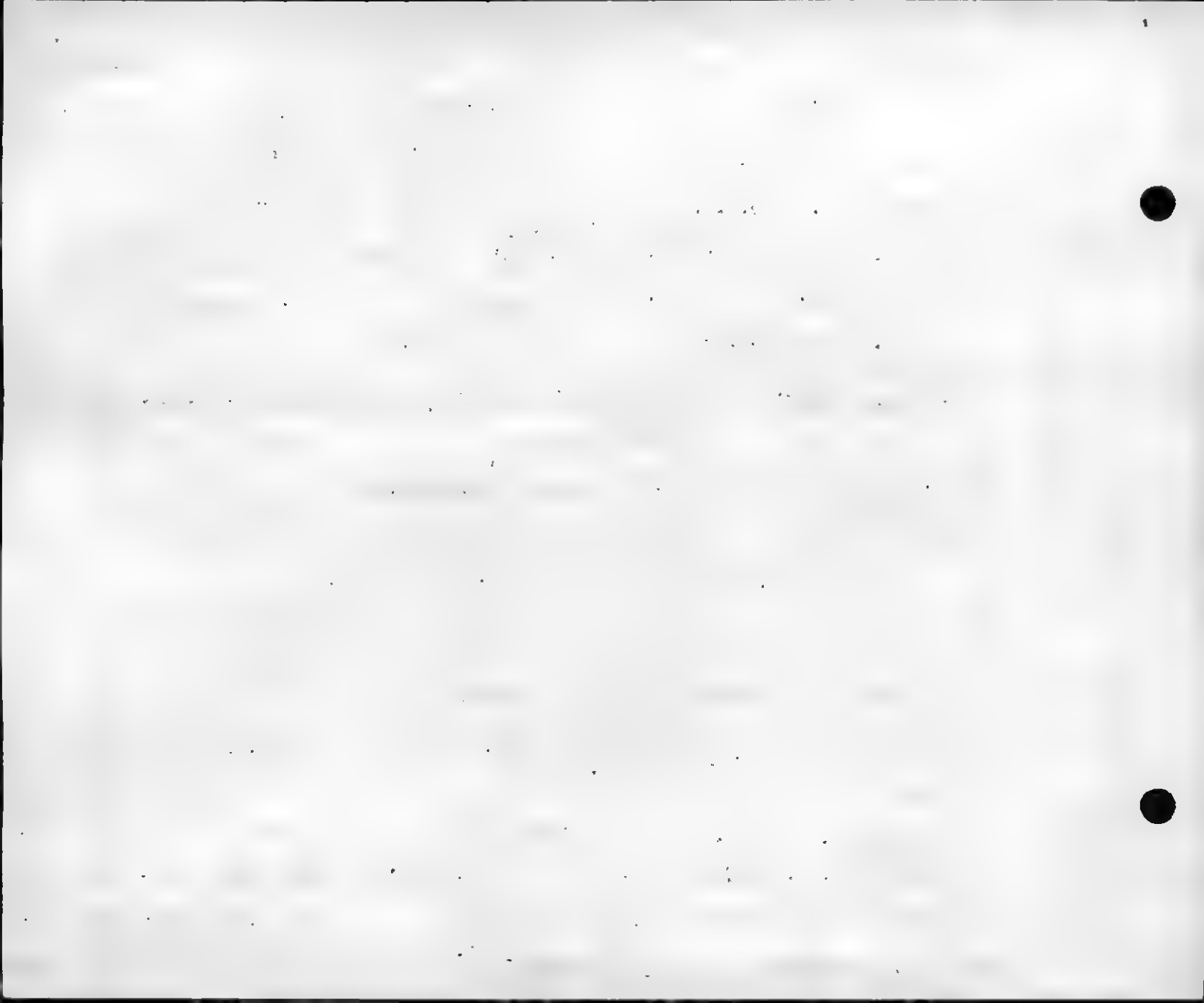
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

2271

Item #8, Film 3450 7/24/68

CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|---|------------------------|--|---|--|--|
| 1. DECEASED-NAME
(Type or print) | | First
JOHN | Middle
JAMES | Last
HOLLIFIELD | 2a. DATE OF DEATH
Month February Day 22 Year 1968 | | 2b. HOUR 6:15 M M |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
August 8, 1900 | | 6. AGE (In years last birthday)
67 YRS | |
| 7a. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md | |
| 10. CITY OR TOWN OF DEATH
Fort Howard | | 11. NAME OF HOSPITAL OR INSTITUTE (If not in hospital give street address)
Veterans Administration Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Guard | | 12b. KIND OF BUSINESS OR INDUSTRY
State Police | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Kingsville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER
Rt. 1 Box 683 | | 14. FATHER'S NAME
First James Middle Hollifield Last | | 15. MOTHER'S MAIDEN NAME
First Nellie Middle Bond Last | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) Yes (If yes give war or dates of service) WW-1 | | 16b. SOCIAL SECURITY NO.
213 16 44 65 | | 17. INFORMANT
Clinical Reds VAH Fort Howard, Md. Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA
71 x 1
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4230
(b) ARTERIOSCLEROTIC HEART DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
CEREBRAL ARTERIOSCLEROSIS AND PULMONARY EMPHYSEMA. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from Dec. 14, 1967 , to Feb. 22, 1968 , that (X) (we) last saw the deceased alive on Feb. 22, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
J. D. Talbert, M.D. DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | 22c. DATE SIGNED
2/23/68 | |
| 22d. PHYSICIAN'S NAME (Type)
J. D. TALBERT, M.D. | | | | 22e. ADDRESS
VA Hospital, Fort Howard, Md. | | | |
| 23a. BURIAL, CREMATION, REINTERMENT
Burial | | 23b. DATE
Feb 26, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National | | 23d. LOCATION (City or town) (County) (State)
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
George J. Gnee | | ADDRESS
4001 Gov Ritchie Hwy | | 25a. REC'D BY REGISTRAR
FEB 27 1968 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

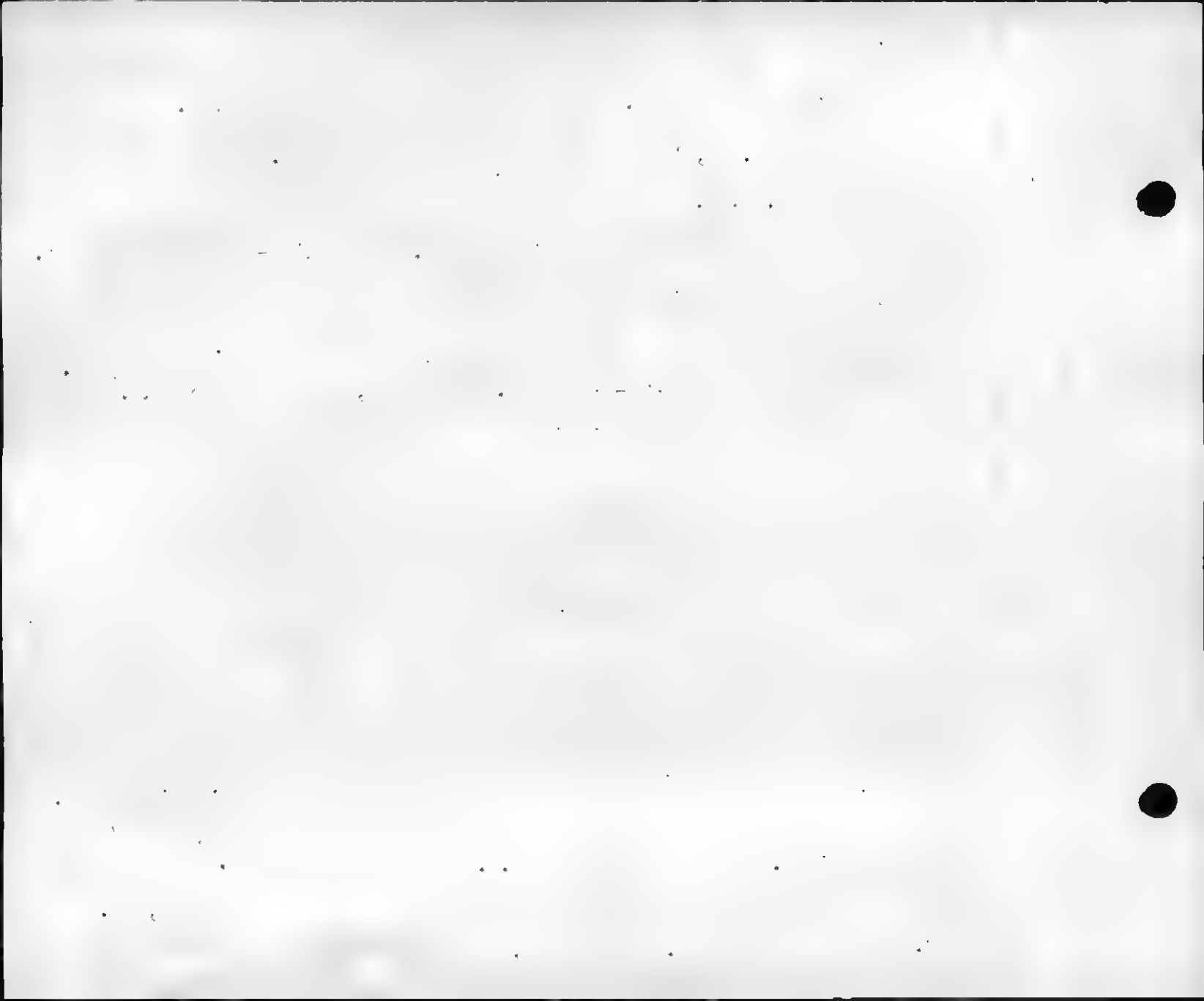


FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

| <div style="text-align: center;"> MEDICAL EXAMINER'S CERTIFICATE OF DEATH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 22222 </div> | | | | | | | | | | | |
|---|-------------------------|--|---|---|--|--|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or Print) | | First
Evald | | Middle
F. | | Last
Holm | | 2a. DATE KNOWN OF DEATH
Month Feb. Day 15 Year 1968 | | 2b. HOUR
9:00 AM | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
Nov. 29, 1906 | | 6. AGE (In years last b. day)
61 YRS | | 7. UNDER 1 YEAR
MONTHS _____ DAYS _____ | | 7. UNDER 24 HRS
HOURS _____ MIN _____ | | 2c. DATE PRONOUNCED DEAD
Month Feb. Day 15 Year 1968 | |
| 7a. BIRTHPLACE (State or foreign country)
West Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md | | | | | |
| 10. CITY OR TOWN OF DEATH
Edgemere | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)
7841 North Cove Rd. | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Wire Mill - Bethlehem Steel Co. | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USJA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Edgemere | | 13d. INS DE CITY, JANES?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
7841 North Cove Road | | | |
| 14. FATHER'S NAME
First Frank Middle _____ Last Holm | | | 15. MOTHER'S MAIDEN NAME
First Anna Middle C. Last Anderson | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) Will | | | | | |
| 16b. SOCIAL SECURITY NO
214-26-8758 | | 17. INFORMANT (Wife)
Mrs. Ethel Holm, 7841 North Cove Rd. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) HSC-V- Disease
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
None | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
_____, _____, 19____
HOUR A.M. _____ P.M. _____ | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No _____ City or Town _____ County _____ State _____ | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE
Melvin B. Davis | | EXAMINER'S NAME (Type)
Melvin B. Davis | | M.D.
M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> 6800 Mornington Rd.
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 22b. DATE SIGNED 2/15/68
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Dundalk,
ADDRESS (Street, city, town, or county) Md. 21222 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
2/19/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | | | | | |
| 24. FUNERAL DIRECTOR
John J. Duda, 7922 Wise Ave. Dundalk, Md. | | ADDRESS | | 25a. REC'D BY REGISTRAR
FEB 19 1968 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

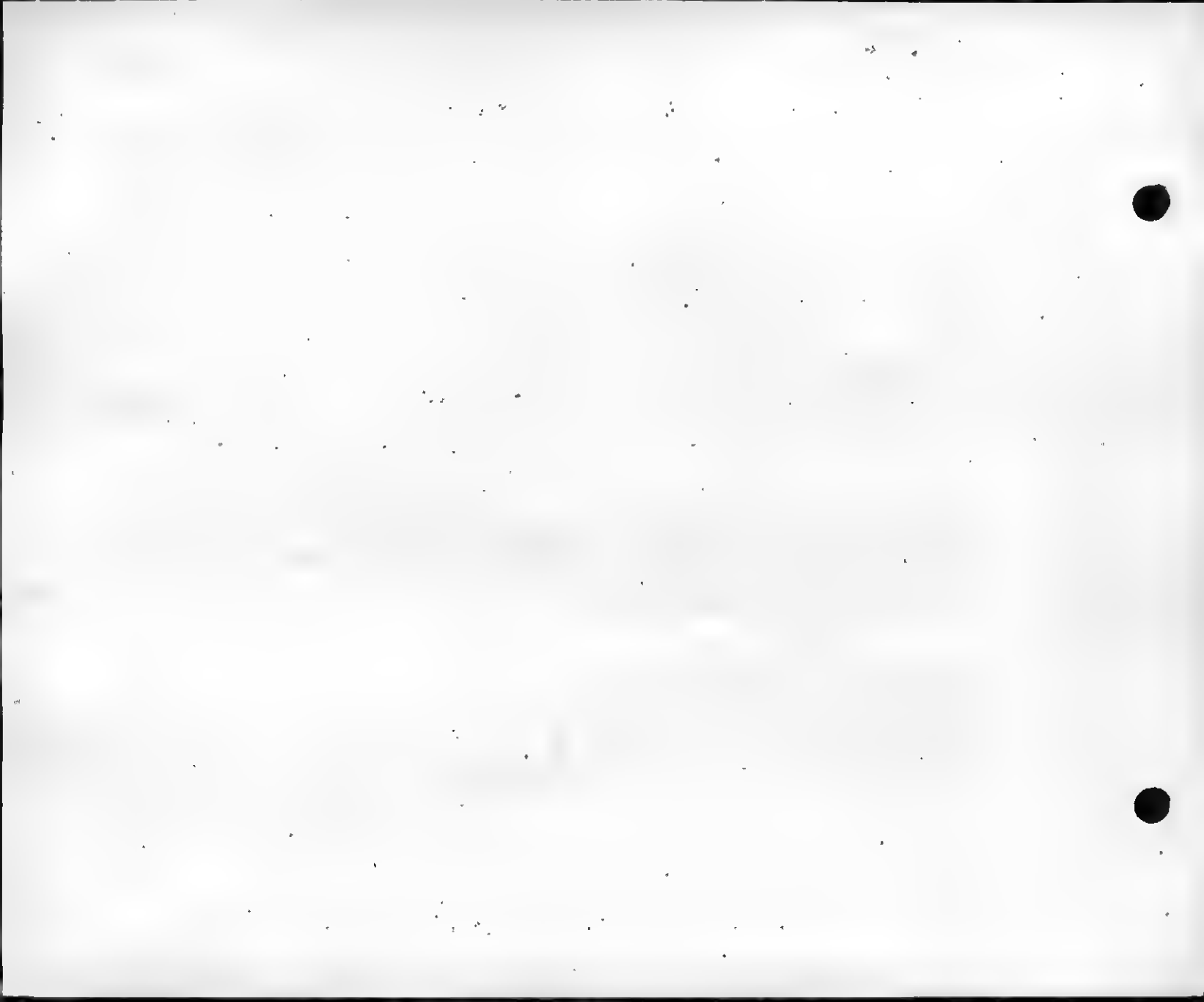
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

1
22223

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

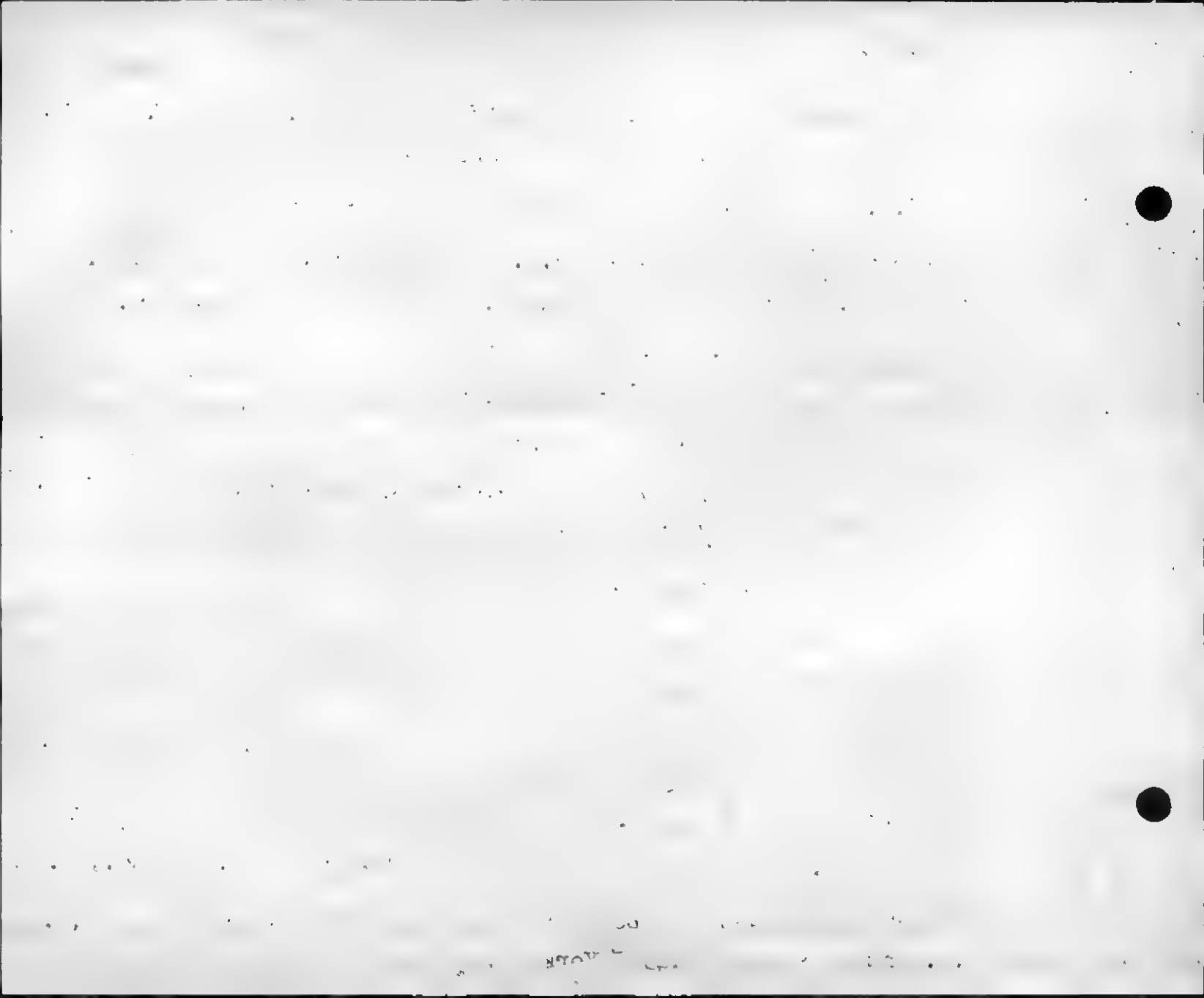
| | | | | | | | |
|---|--|---|--------------|---|---|---|----------------------|
| 1. DECEASED NAME
(Type or print) | | First
DAISY | Middle
A. | Last
HOOD | 2a. DATE OF DEATH
Month
2
Day
9
Year
1968 | | 2b. HOUR
11:10 AM |
| 3 SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
August 31, 1973 | | 6. AGE (In years
last birthday)
94 YRS | |
| 7a. BIRTHPLACE (State or foreign
country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Greater Balto. Med. Center | | 12a. USUAL OCCUPATION (Kind of work done
during most of work life, even if retired)
Nurse | | 12b. KIND OF BUSINESS OR
INDUSTRY
None | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution
admission) STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Lutherville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
First
Thomas Maxwell | | Middle
Last | | 15. MOTHER'S MAIDEN NAME
First
Annie Barlow | | Middle
Last | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown)
no | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
None | | 17. INFORMANT
Family records | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral thrombosis with extensive infarction</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Arteriosclerotic cardiovascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>4221</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Aspiration bronchopneumonia and pulmonary embolus</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH?
YES | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION
Street or R.F.D. No | | City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/29</u> , 19 <u>68</u> , to <u>2/9</u> , 19 <u>68</u> , that (I) (we) last
saw the deceased alive on <u>2/9</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>John E. Adams</u> | | | | DEGREE
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/9/68 | |
| 22d. PHYSICIAN'S NAME (Type)
John E. Adams, M. D. | | | | 22e. ADDRESS
Greater Baltimore Medical Center | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
Feb. 12, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodmont Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Towson, Md. | |
| 24. FUNERAL DIRECTOR
<u>John Burns Sons</u> | | | | ADDRESS
<u>Luttrell</u> | | 25a. REC'D BY REGISTRAR
DATE FEB 13 1968 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|--|--|------------------------------------|---|---|--|--|--|--------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED NAME (Type or print) | | | First | | Middle | | Last | | 2a. DATE OF DEATH | | |
| DORA | | | E. | | HOPPER | | Feb. | | Month 9 Day 1968 | | |
| 3 SEX | | | 4 RACE | | 5 DATE OF BIRTH | | | 6 AGE (In years most birthday) | | 7b. HOUR | |
| Female | | | White | | 4-3-1873 | | | 94 YRS | | 7:15 PM | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | |
| N.Y. | | | USA | | | | | Baltimore | | Md | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore 21212 | | | Armocost N.E. | | | Housewife | | | Own Home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INS DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md. | | | | | | Balto. | | | | 4212 Kelway Rd. | |
| 14. FATHER'S NAME | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | |
| Otis | | | C. | | Smith | | Maria | | Perlee | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | |
| No | | | 051-14-7052 | | | Mrs. Ruth Clegg | | | Above | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) PNEUMONIA | | | | | | | | | | 3 DAYS | |
| 4124 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) CHRONIC BRAIN SYNDROME | | | | | | | | | | 3 YEARS | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) ARTERIO SCLEROSIS GENERALIZED | | | | | | | | | | YEARS. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| A.S.C.V. DISEASE | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME FARM, STREET FACTORY, OFFICE BUILDING, ETC) | | | 21f. LOCATION Street or R.F.D. No | | | City or Town | | County |
| | | | | | | | | | | | State |
| 22a. I certify that (I) (this hospital) attended the deceased from 1950 to FEB. 9, 1968, that (I) (we) last saw the deceased alive on FEB. 9, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | 22c. DATE SIGNED | |
| Arthur Karfgin M.D. DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | | | | | | | | 2/10/68 | |
| 22d. PHYSICIAN'S NAME (Type) Dr. Arthur Karfgin | | | | | | | | | | 22e. ADDRESS | |
| | | | | | | | | | | 1532 Havenwood Rd., Balto., Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | | 2-13-68 | | Beechwood | | | New Rochelle N.Y. | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| H.W. Jenkins & Sons Co. 4905 York Rd., Balto., Md. | | | | | | DATE FEB 13 1968 | | Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| George | | | Henry | | | Houck | | | Month - Day - Year | | |
| 3 SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6 AGE (In years last birthday) | | |
| Male | | | White | | | 7-17-91 | | | 76 YRS | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | |
| Maryland | | | U.S.A. | | | | | | Baltimore | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Randallstown | | | Baltimore Co. Gen. Hosp. | | | Police - P.R.P. | | | #7 | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| Md. | | | Baltimore | | | Baltimore | | | 3637 Coronado Rd | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | |
| Milton | | | Houck | | | AGNES | | | AMOS | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | |
| No. | | | 717-01-7824 | | | Amelia J. Houck - Same | | | | | |
| 18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) | | | | | | | | | | Metastatic carcinoma | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) | | | | | | | | | | carcinoma of stomach | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | HOUR A.M. Month Day Year | | | | | | | | |
| 21a. INJURY OCCURRED | | | 21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21c. LOCATION | | | Street or R.F.D. No. City or Town County State | | |
| White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost | | | | | | | | | | | |
| saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the | | | | | | | | | | | |
| causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | 22c. DATE SIGNED | | | | | |
| Charles V. Patricio M.D. DEGREE | | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | 2/28/68 | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | |
| | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | | 3-1-68 | | | Lorraine Pk. Cemetery | | | Baltimore, Md. | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REG'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| Elsworth Armstrong - 4600 Liberty Avenue | | | | | | DA FEB 29 1968 | | | Charles Judge | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

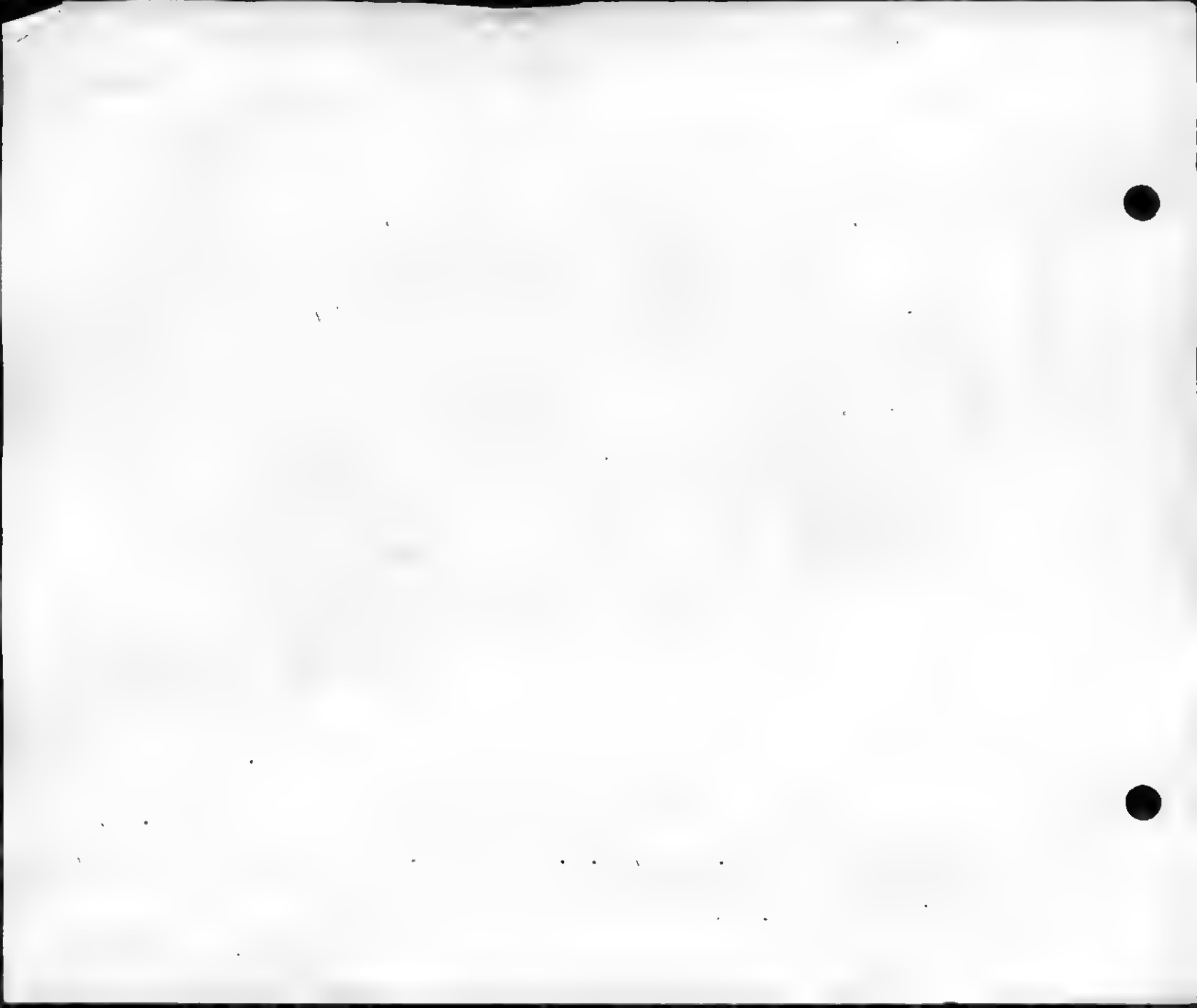
22226

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

2214

| | | | |
|---|----------------------------------|---|--|
| 1 PLACE OF DEATH
a COUNTY <i>Baltimore</i> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE <i>Maryland</i> b COUNTY <i>Baltimore</i> | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Lindenwood</i> | | c LENGTH OF STAY IN 15 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<i>1715 W. Popple Road</i> | | d STREET ADDRESS
<i>1715 W. Popple Road</i> | |
| e IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3 NAME OF DECEASED
(Type or print)
First <i>Villard</i> Middle <i>Alan</i> Last <i>Howard</i> | | 4. DATE OF DEATH
Month <i>February</i> Day <i>15</i> Year <i>1968</i> | |
| 5. SEX
<i>Male</i> | 6. COLOR OR RACE
<i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>November 18, 1917</i> |
| 9. AGE (In years lost birthday)
<i>56</i> yrs | | 10. IF UNDER 1 YEAR
Months <i>5</i> Days <i>10</i> Hours <i>10</i> Min | 11. IF UNDER 24 HRS.
Months <i>5</i> Days <i>10</i> Hours <i>10</i> Min |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Electrician</i> | | 10b KIND OF BUSINESS OR INDUSTRY
<i>Self-employed</i> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.</i> | |
| 13. FATHER'S NAME
<i>James F. Howard</i> | | 14. MOTHER'S MAIDEN NAME
<i>Bessie A. Alban</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO
<i>217-07-1034</i> | |
| 17. INFORMANT
<i>Family records</i> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>4109</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) <i>Coronary artery disease</i>
(c) <i>Coronary occlusion</i> | | INTERVAL BETWEEN ONSET AND DEATH
<i>minutes</i>
<i>39 days</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <i>19</i> p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>Sept. 1958</i> , to <i>Feb. 15, 1968</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that death occurred at <i>19</i> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>William F. Fritz</i> | | 22b. DATE SIGNED
<i>Feb. 16, 1968</i> | |
| 22c. PHYSICIAN'S NAME (Type)
<i>WILLIAM F. FRITZ, M.D.</i> | | 22d. ADDRESS
<i>2 W. University Parkway, Balto 18, Md.</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>burial</i> | | 23b. DATE THEREOF
<i>Feb. 17, 1968</i> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<i>Jessops Methodist Cem.</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Rockville, Md.</i> | |
| 24. FUNERAL DIRECTOR
<i>John Wynn's Sons, To wor, Md.</i> | | 25a. REC'D BY REGISTRAR
DATE <i>FEB 20 1968</i> | |
| 25b. REGISTRAR'S SIGNATURE
<i>Charles Jones</i> | | | |



X

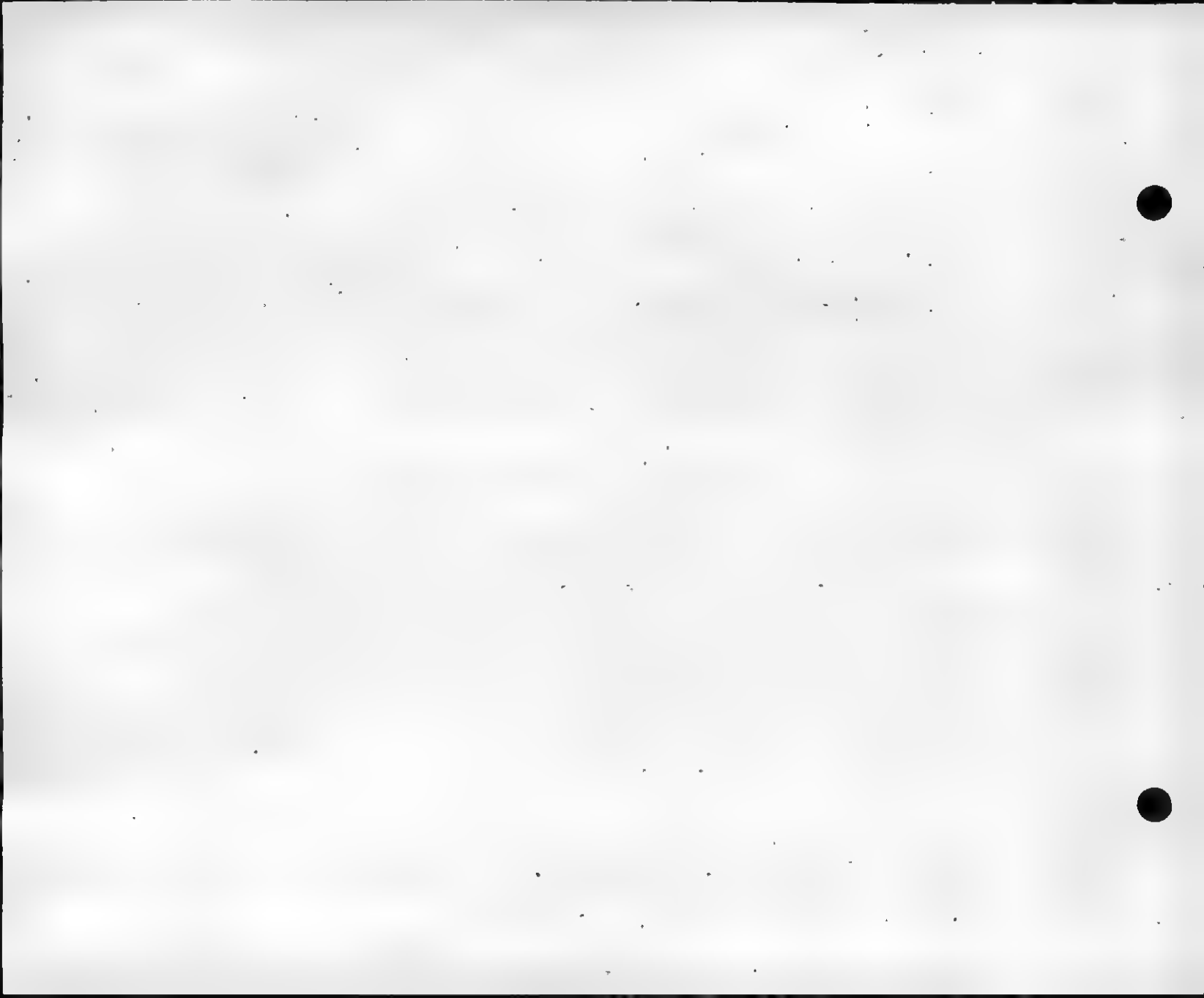
1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|--|--|---|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) Theresa | | | First Middle Last Huber | | | 2a. DATE OF DEATH Feb. 16 19 68 | | | 2b. HOUR 7p.m. | | |
| 3. SEX Female | | | 4. RACE White | | | 5. DATE OF BIRTH Oct. 9, 1871 | | | 6. AGE (In years lost birthday) 96 YRS | | |
| 7a. BIRTHPLACE (State or foreign country) Germany | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Balto. County Md | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's Hosp | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) Maryland | | | 13b. CITY OR TOWN Baltimore | | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13d. STREET AND NUMBER 4211 Chapel Rd. | | |
| 14. FATHER'S NAME First Middle Last - Zinser | | | 15. MOTHER'S MAIDEN NAME First Middle Last Unknown | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | |
| 17. INFORMANT Mrs Teresa Clark - 4211 Chapel Rd. | | | Address | | | | | | | | |
| 18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 493 X
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 days | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Advanced arteriosclerosis | | | | | | | | | | | |
| 19a. DATE OF OPERATION None | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July , 19 62 , to Feb. 16 , 19 68 , that (I) (we) last saw the deceased alive on Feb. 14 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Theodore E. Evans, M.D. DEGREE M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | | | | | | | 22c. DATE SIGNED 2-17-68 | | |
| 22d. PHYSICIAN'S NAME (Type) Theodore E. Evans, M.D. | | | | | | 22e. ADDRESS 9660 Belair Road 21236 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 2/20/68 | | | 23c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cem. | | | 23d. LOCATION (City or Town) (County) (State) Fullerton, Md. | | |
| 24. FUNERAL DIRECTOR John C. Miller, Inc. 6415 Belair Rd. | | | | | | 25a. REC'D BY REGISTRAR DATE FEB 23 1968 | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

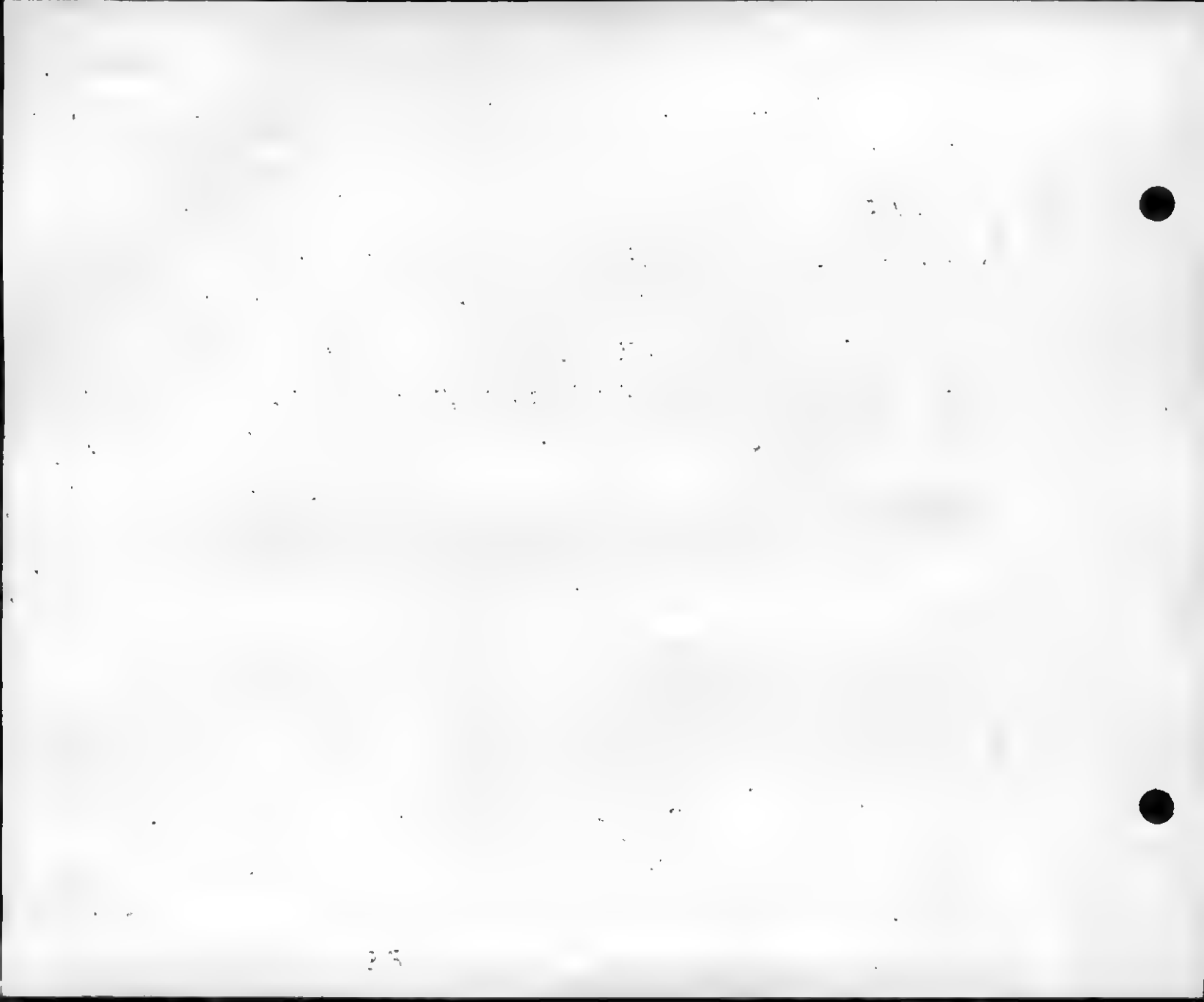
VR A15 (4)
300A REV. 1/68

02228

02216

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(Type or print) <u>Helen Marie Hunt</u> | | | 20. DATE OF DEATH
Month <u>2</u> Day <u>23</u> Year <u>68</u> | | | 2b. HOUR
<u>10³⁵ PM</u> | |
| 3. SEX
<u>Female</u> | | 4. RACE
<u>White</u> | | 5. DATE OF BIRTH
<u>10-9-95</u> | | 6. AGE (In years
last birthday)
<u>72</u> YRS | |
| 7a. BIRTH-PLACE (State or foreign
country)
<u>MARYLAND</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<u>Baltimore</u> Md. | |
| 10. CITY OR TOWN OF DEATH
<u>Catonsville</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital
give street address)
<u>House in the Pine</u> | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired)
<u>Housewife</u> | | 12b. KIND OF BUSINESS OR
INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before
admission) STATE <u>Md</u> | | 13b. COUNTY
<u>Baltimore</u> | | 13c. CITY OR TOWN
<u>Baltimore</u> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
<u>625 Aldershot Rd</u> | | 14. FATHER'S NAME First Middle Last
<u>EDWARD H. ROGERS</u> | | 15. MOTHER'S M.A.D.E.N. NAME First Middle Last
<u>UNKNOWN</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMY FORCES?
Yes, no, or unknown <u>NO</u> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
<u>219-25-9764</u> | | 17. INFORMANT
<u>HELEN M. DILLALL 625 ALPERSHOTT RD</u> Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u>
<u>4120</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. (b) <u>Hypertension Cerebral Vascular Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>10mm?</u> | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>1 mo</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Liver with Metastases, Poor General Nutrition</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
White <input type="checkbox"/> Not white <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>68</u> to <u>Feb 23</u> , 19 <u>68</u> , that (I) (we) last
saw the deceased alive on <u>Feb 22</u> , 19 <u>68</u> ; and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>J. Nelson McKay</u> M.D.
DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED
<u>2-23-68</u> | | | |
| 22d. PHYSICIAN'S
NAME (Type)
<u>J. NELSON MCKAY</u> | | | | 22e. ADDRESS
<u>6014 EDMONDSON AVE</u> | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE
<u>2-26-68</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>DAVID RIDGE CEMETERY BALTO</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>MD.</u> | |
| 24. FUNERAL DIRECTOR
<u>WEBER FUNERAL HOME 5314 EDMONDSON AVE</u> | | 25a. REC'D BY REG. STRAR
<u>DATE FEB 26 1968</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |



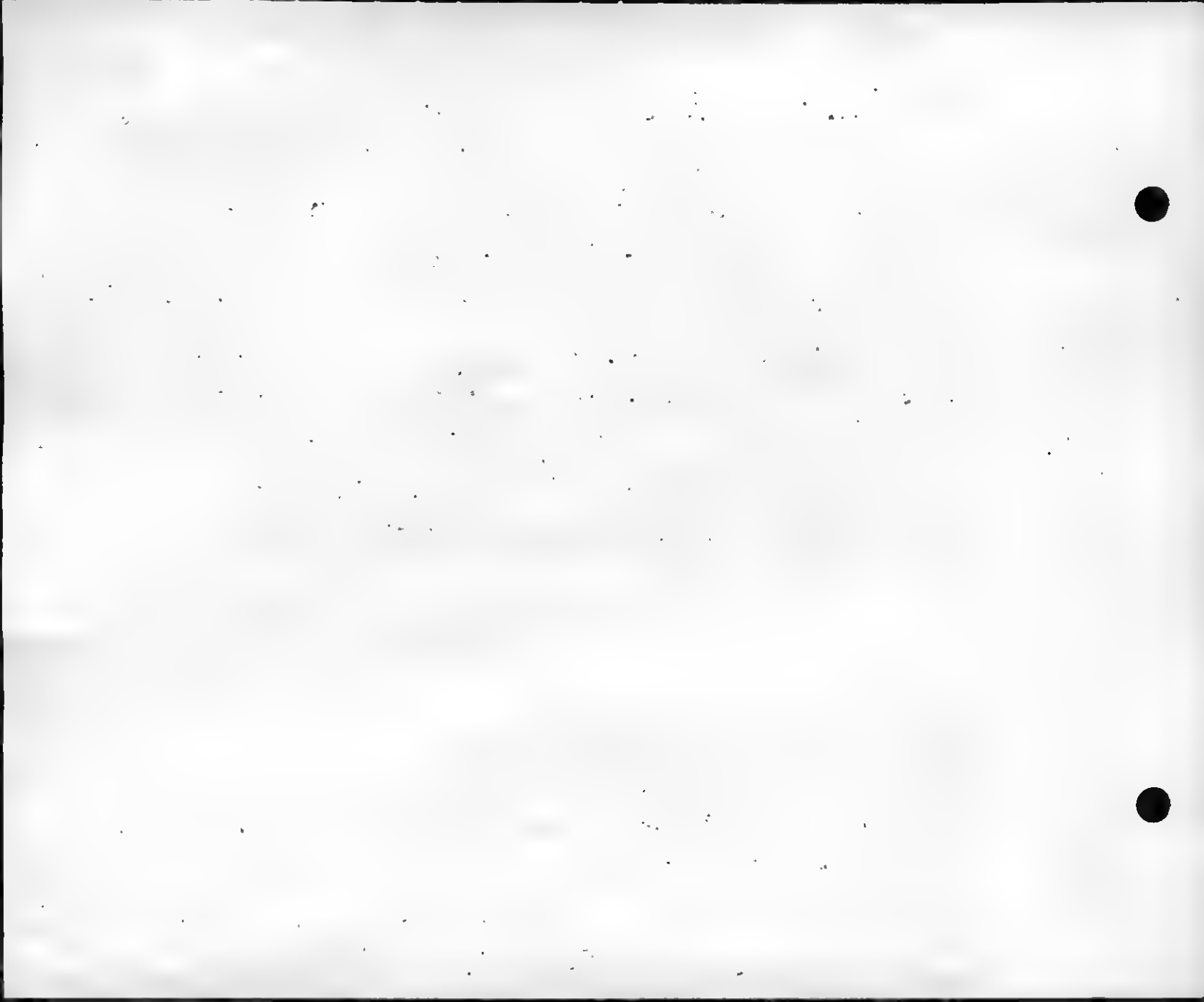
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD 2220
MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MAYLAND 21201
CERTIFICATE OF DEATH

02217

| | | | | | |
|---|--|---|---|---|---|
| 1 DECEASED NAME (Type or print) Joseph Carl Thnat | | | 2a DATE OF DEATH Feb. 17 1968 | | 2b HOUR 1:30 PM |
| 3 SEX Male | 4 RACE Can | 5. DATE OF BIRTH 3-6-1895 | | 6 AGE (In years last birthday) 72 YRS. | 7 UNDER 1 YEAR MONTHS 0 DAYS 0 |
| 7a BIRTHPLACE (State or foreign country) Penna | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 COUNTY OF DEATH Baltimore Md. | | |
| 10 CITY OR TOWN OF DEATH Towson | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Capetator Balt. Med Ctr | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY unknown |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Penna | 13b COUNTY Phoenix | 13c CITY OR TOWN Phoenix | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e STREET AND NUMBER Sweet Air Rd. Box 44 | |
| 14. FATHER'S NAME First Michael Middle Thnat | | | 15. MOTHER'S MAIDEN NAME First unknown Middle unknown Last unknown | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown unknown (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO unknown | 17 INFORMANT Patients chart. Address unknown | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) Cardio-Respiratory arrest. | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Possible Sudden myo cardiac infarction. | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Lung tumor and congestive failure | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY HOUR A.M. 19 Month 2 Day 17 Year 1968 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | |
| 21d INJURY OCCURRED <input type="checkbox"/> White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f. LOCATION Street or R.F.D. No 2-5 City or Town PA. County PA. State PA. | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-5-1968 to 2-17-1968 , that (I) (we) last saw the deceased alive on 2-17-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE Rahm Bassile | | | | 22c. DATE SIGNED 2-17-68 | |
| 22d. PHYSICIAN'S NAME (Type) Rahm m. Bassile | | | | 22e. ADDRESS | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b DATE 2-21-68 | | 23c NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery | |
| 24 FUNERAL DIRECTOR Wm. Cook-Brooks Inc. | | ADDRESS 1017 St Paul St Baltimore, Md. 21202 | | 25a REC'D BY REGISTRAR FEB 20 1968 DATE | |
| | | | | 25b. REGISTRAR'S SIGNATURE Charles Jones | |

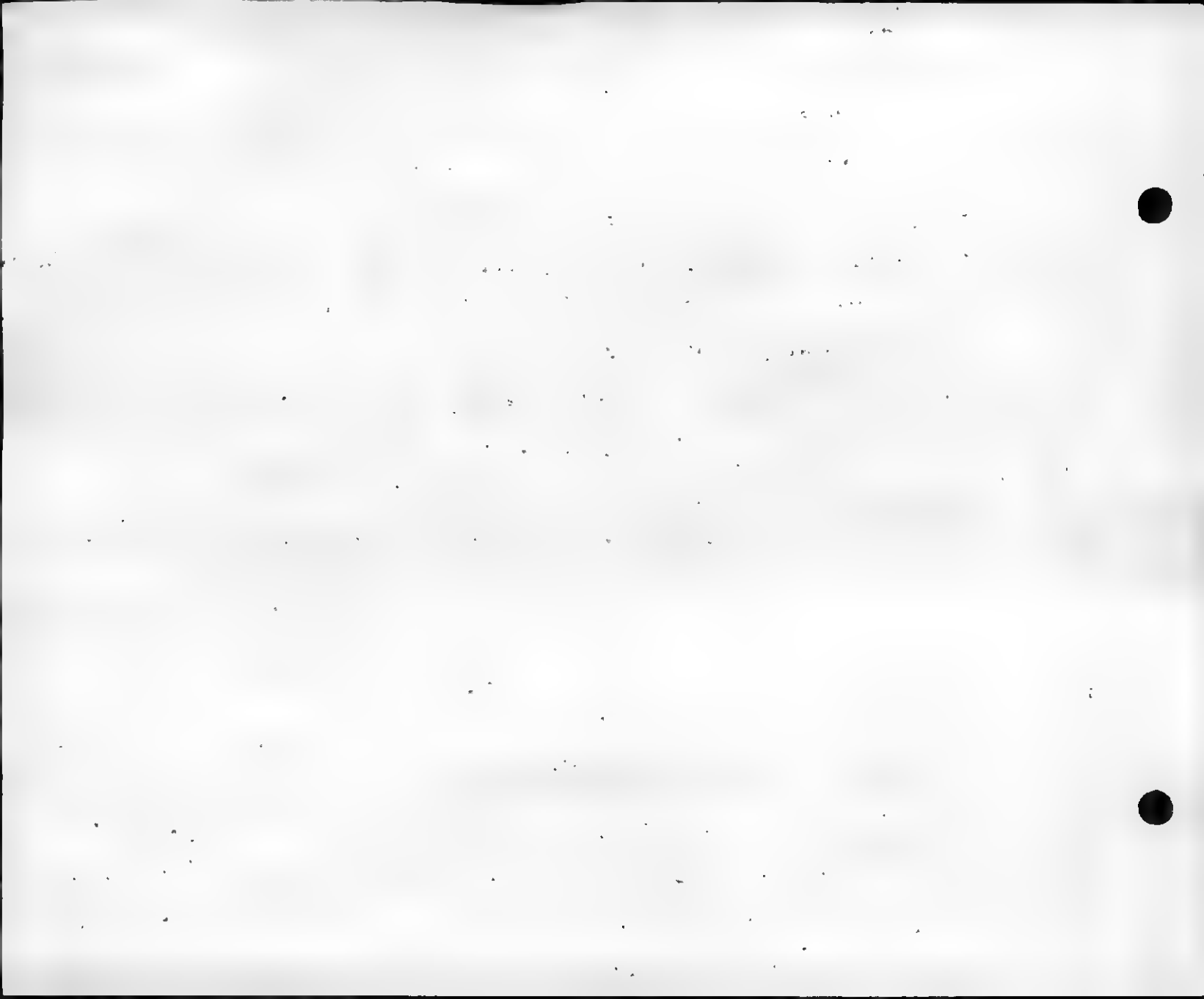


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD 2210
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | |
|---|----------------|--|---|--|--|
| 1. DECEASED NAME
(Type or print) First Middle Last
Eva W. Johnson | | | 2a. DATE OF DEATH
Month Day Year
2 8 68 | | 2b. HOUR
M |
| 3. SEX
Female | 4. RACE
Cau | 5. DATE OF BIRTH
11/18/87 | | 6. AGE (In years last birthday)
80 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)
District Columbia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md |
| 10. CITY OR TOWN OF DEATH
Catonsville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Summit Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE
Md | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Catonsville | 13d. INSIDE CITY (A.R.T.S.)
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER
128 Cherrydell Rd |
| 14. FATHER'S NAME First Middle Last
Unknown Harris | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Ellen Webb | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) (If yes give war or dates of service)
No | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address
Charles G. Johnson Same as 13e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>myocardial infarction</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last
(b) <u>chronic myocarditis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>atherosclerotic cardiovascular disease</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 da.
5 yr.
10 yr. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY)
OFFICE BUILDING, ETC | | 21f. LOCATION Street or R.F.D. No City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-18</u> , 19 <u>62</u> , to <u>2-8-68</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2-5</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Wilmer K. Gallagher</u> | | | | 22c. DATE SIGNED
2-9-68 | |
| 22d. PHYSICIAN'S NAME (Type)
<u>Wilmer K. Gallagher</u> | | | | 22e. ADDRESS
<u>6209 Frederick Ave., Balt. 21228 Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
2/12/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn | |
| 23d. LOCATION (City or Town)
Woodlawn | | 23e. (County)
Balt | | 23f. (State)
Md | |
| 24. FUNERAL DIRECTOR
Wm. Cook-Brooks West Inc Balt. Md. 21228 | | | | 25a. REC'D BY REG. STRAR
DATE FEB 13 1968 | |
| 25b. REGISTRAR'S SIGNATURE | | | | | |



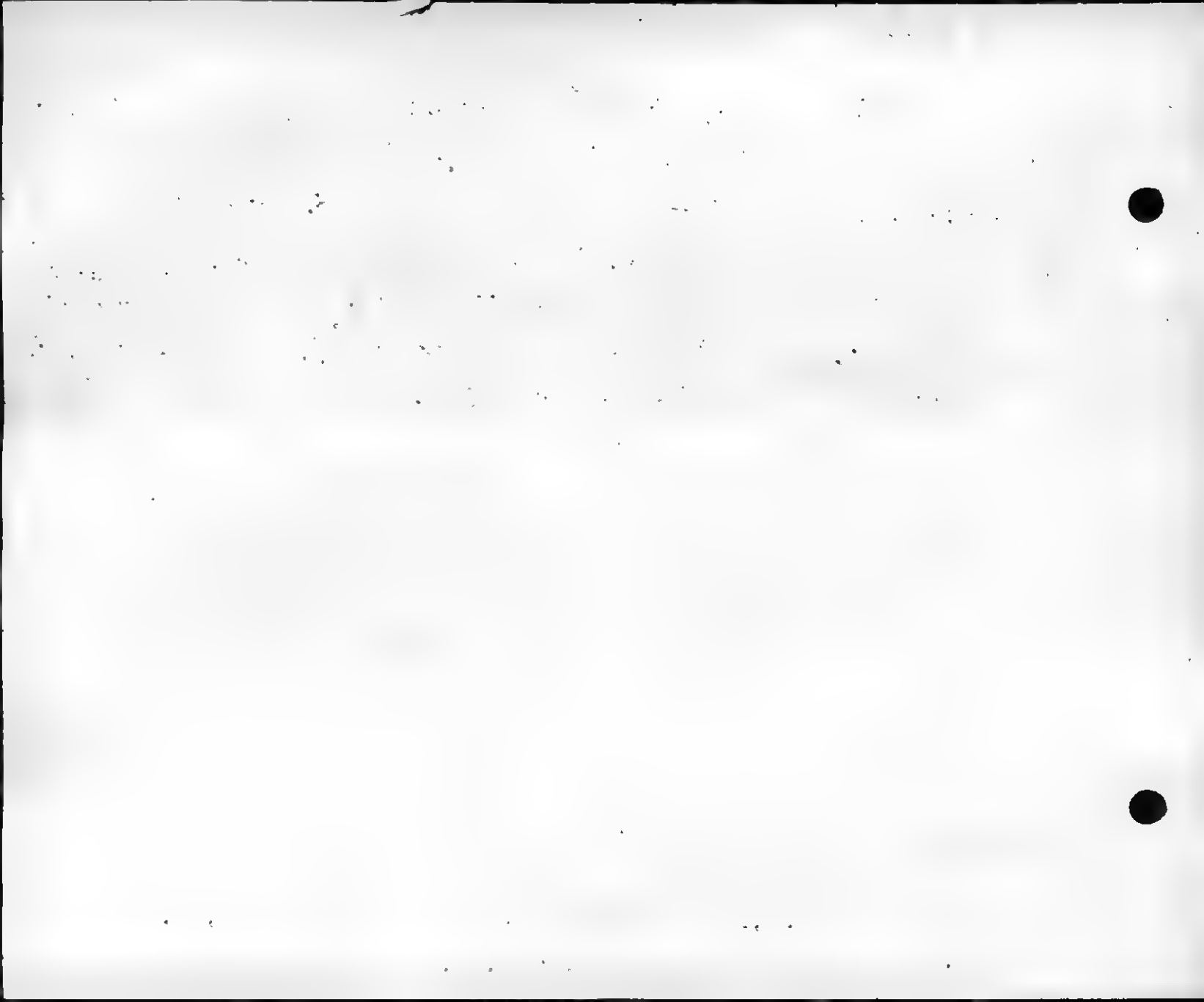
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|---|--|--|---|---|------------------------|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1 DECEASED-NAME (Type or print) Lawrence, Haze, Johnson | | | | | 2a DATE OF DEATH: 2 Month 9 Day 68 | | 2b HOUR 12:30 M | | |
| 3. SEX MALE | | 4 RACE CAUCASIAN | | 5. DATE OF BIRTH 7/29/18 | | 6 AGE (In years last birthday) 49 YRS | | F UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| 7a BIRTHPLACE (State or foreign country) Lafayette, Tenn | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore | | Md | |
| 10 CITY OR TOWN OF DEATH BALTO | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GBMC | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD. | | 13b COUNTY BALTO | | 13c CITY OR TOWN BALTO | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER #27 2805 LOUISIANA AVE | |
| 14 FATHER'S NAME First Middle Last Joseph Johnson | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth Johnson | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No | | 16b. SOCIAL SECURITY NO 410-16-9050 | | 17 INFORMANT Pt's chart | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Brucellosis as a pleural effusion
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a ACCIDENT WAS UNDERLYING
<input type="checkbox"/> DIRECT CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, nat'l medical examiner) | | 21b TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb. 1, 1968 , to Feb. 9, 1968 , that (I) (we) last saw the deceased alive on Feb. 9, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | | |
| 22b. SIGNATURE Anastacia Fabie | | | | DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c DATE SIGNED Feb. 9, 1968 | | | |
| 22d PHYSICIAN'S NAME (Type) ANASTACIA FABIE | | | | 22e ADDRESS GBMC | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b DATE Feb. 12, 1968 | | 23c NAME OF CEMETERY OR CREMATORY Lakeview Cemetery | | 23d LOCATION (City or Town) (County) (State) Randallstown, Md. | | | |
| 24. FUNERAL DIRECTOR G. Truman Schwab | | | | ADDRESS 3512 Frederick Ave, Balto. Md. | | 25a REC'D BY REGISTRAR FEB 13 1968 | | 25b. REGISTRAR'S SIGNATURE | |

MEDICAL CERTIFICATION



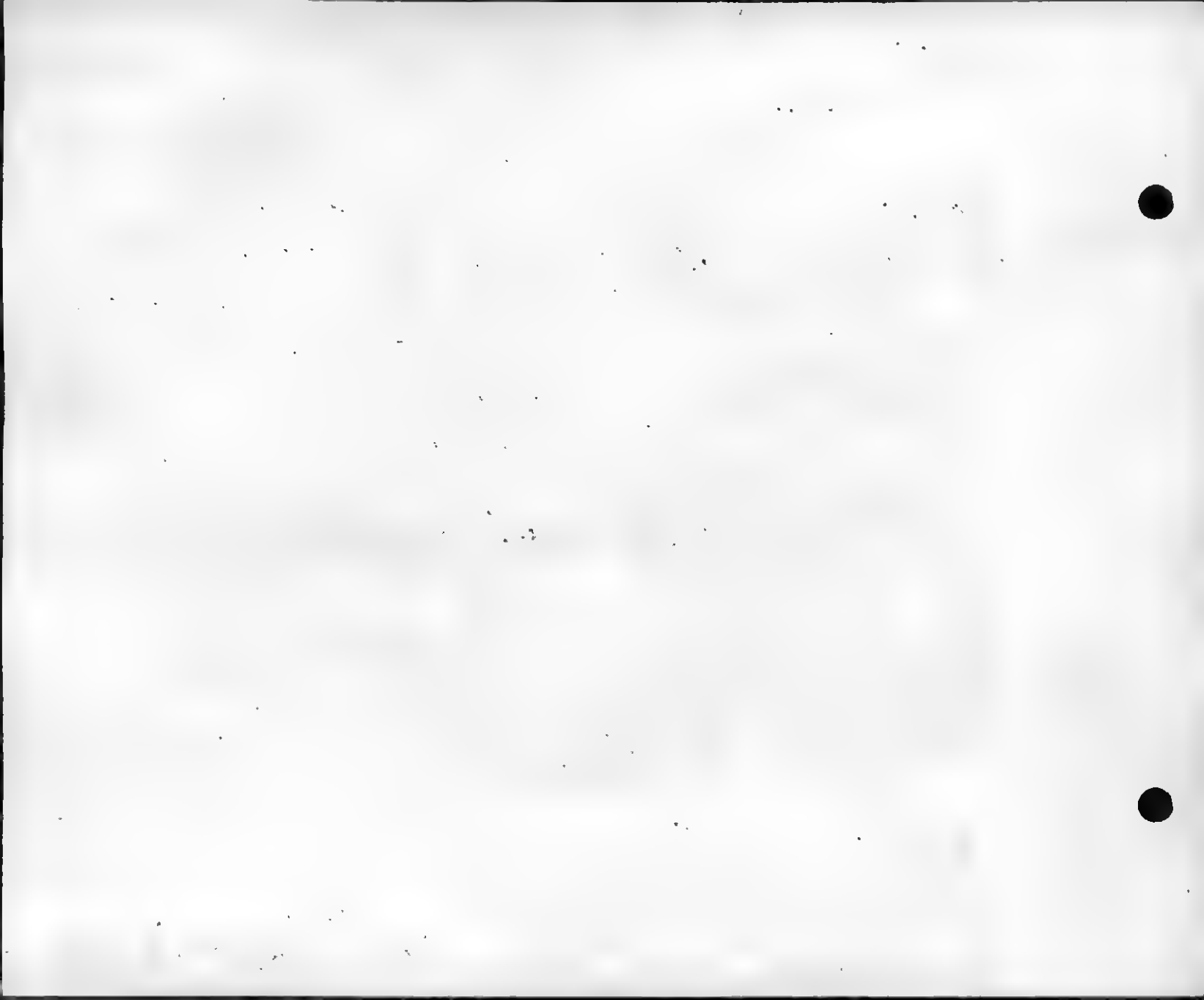
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111 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | | |
|--|--|--|---|---|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) LLOYD M. JONES | | | 2a. DATE OF DEATH 2 Month 24 Day 68 Year | | | 2b. HOUR M | | | |
| 3. SEX M | | 4. RACE W | | 5. DATE OF BIRTH 9/11/19 | | 6. AGE (In years last birthday) 48 YRS | | F UNDER 1 YEAR MONTHS DAYS
F UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) MAINE | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH BALTIMORE Md | | | |
| 10. CITY OR TOWN OF DEATH CATONSVILLE | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 205 ROLLINGBROOK WAY | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) MARINE SURV. | | 12b. KIND OF BUSINESS OR INDUSTRY SHIP | | | |
| 13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE MD | | 13b. COUNTY BALTO | | 13c. CITY OR TOWN CATONSVILLE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 205 ROLLINGBROOK WAY | |
| 14. FATHER'S NAME First Middle Last ONSLOW JONES | | | | 15. MOTHER'S MAIDEN NAME First Middle Last ELIZABETH TAYLOR | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. 017-14-5773 | | 17. INFORMANT LENA M. JONES | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Cardiac Arrhythmia
DUE TO, OR AS A CONSEQUENCE OF
(b) Coronary Artery Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) Arteriosclerosis + Hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June , 19 65 , to 24 Feb , 19 68 , that (I) (we) last saw the deceased alive on 24 Feb , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE William J. Bryson M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED 26 Feb-68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 2/27/68 | | 23c. NAME OF CEMETERY OR CREMATORY LORRAINE | | 23d. LOCATION (City or Town) (County) (State) BALTO. CO. MD | | | |
| 24. FUNERAL DIRECTOR E.S. MACNABB | | ADDRESS 301 FREDERICK ST | | 25a. REC'D BY REGISTRAR DATE FEB 27 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

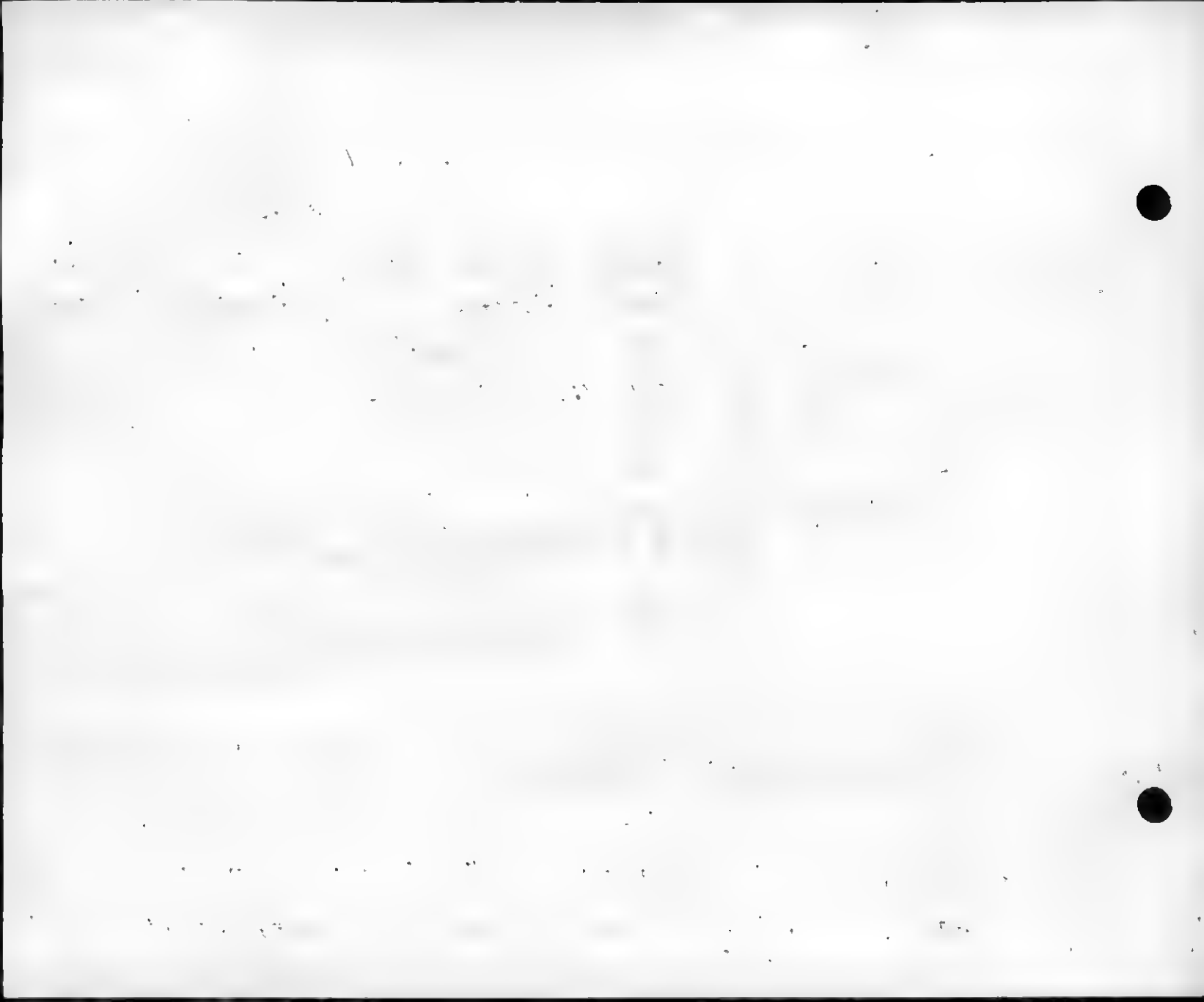


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|--|--|--|--|--|---|---|--|--|
| 1 DECEASED-NAME
(Type or print) | | First
WILLIAM | | Middle
JOSEPH | | Last
KADE | | 2a DATE OF DEATH
Month Day Year
February 25, 1968 | | 2b HOUR
12:05 PM |
| 3. SEX
male | | 4 RACE
white | | 5. DATE OF BIRTH
Sept. 21, 1887 | | 6. AGE (In years last birthday)
86 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN |
| 7a BIRTHPLACE (State or foreign country)
Germany | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md | | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
St. Joseph Hospital | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Trucker | | 12b KIND OF BUSINESS OR INDUSTRY
Moving Co. | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if admission) STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c CITY OR TOWN
Towson | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER
Virginia Avenue | | |
| 14. FATHER'S NAME
First Middle Last
Unknown | | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Unknown | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
No | | 16b. SOCIAL SECURITY NO.
(If yes, give war or dates of service)
None | | 17. INFORMANT
Family records | | Address | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Edema
DUE TO, OR AS A CONSEQUENCE OF
(b) Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF
(c) Arteriosclerotic Cardiovascular Disease | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County | | State |
| 22a. I certify that (I) (this hospital) attended the deceased from February 17, 1968, to February 25, 1968, that (I) (we) last saw the deceased alive on Feb. 25, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b SIGNATURE
Antonio G. de Leon M.D.
DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | | | | | | | 22c DATE SIGNED
2-25-68 | | |
| 22d. PHYSICIAN'S NAME (Type)
Antonio G. de Leon, M.D. | | | | 22e ADDRESS
7620 York Rd., Towson, Md. 21204 | | | | | | |
| 23a B. RIAL CREMATION, REMOVAL (Specify) | | 23b DATE
Feb. 28, 1968 | | 23c NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d LOCATION (City or Town)
Baltimore, Maryland | | (County) (State) | | |
| 24 FUNERAL DIRECTOR
J. M. Burns, Jr., Towson, Maryland | | | | 25a. REC'D BY REGISTRAR
DATE FEB 29 1968 | | 25b. REGISTRAR'S SIGNATURE
J. M. Burns, Jr. | | | | |

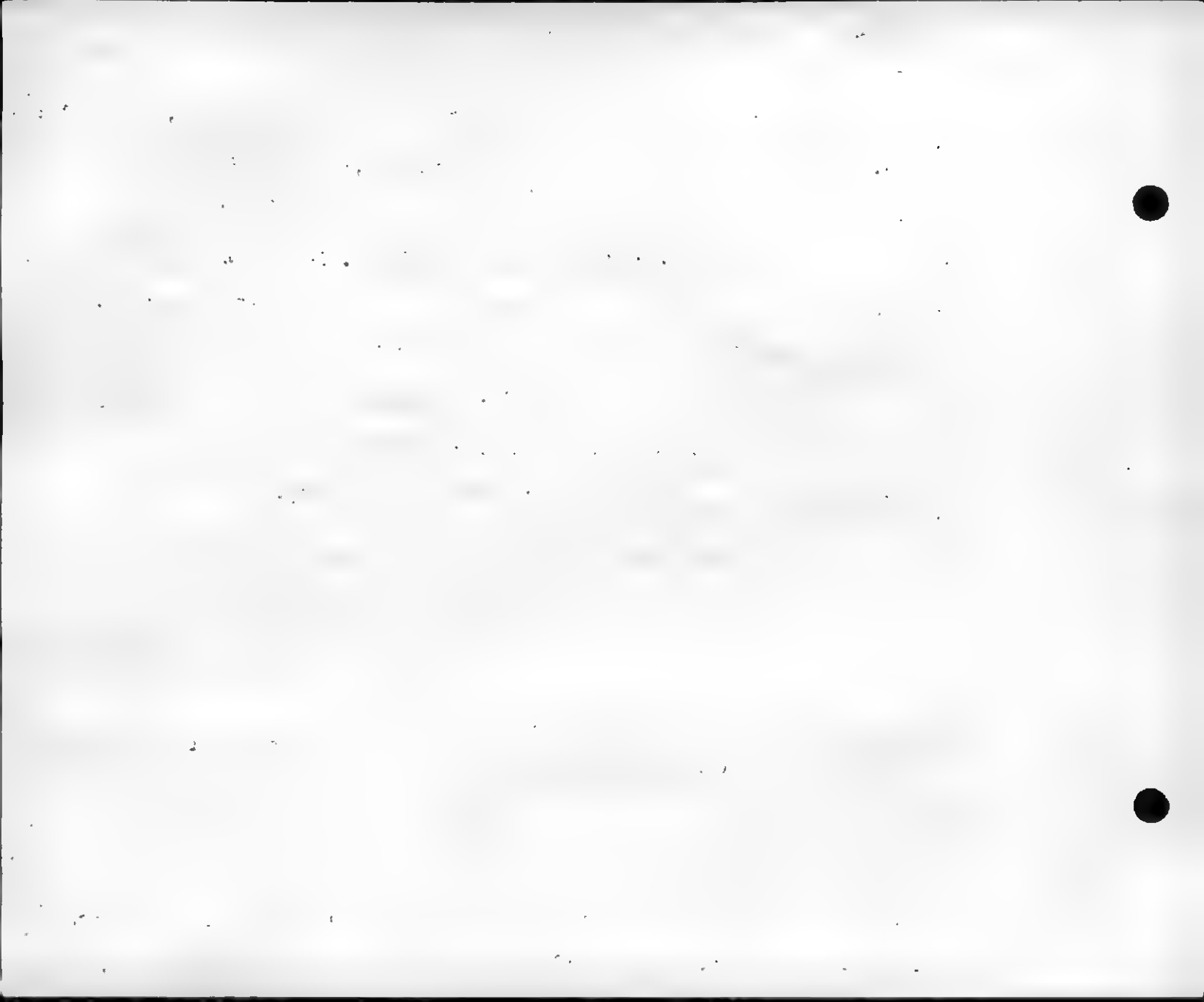


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | |
|--|---|---|--|---|------------------------------------|--|--------------------------------|-------|
| 1. DECEASED-NAME (Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | | 2b. HOUR | |
| WILLIAM FREDERICK KAMPES | | | | | Month Day Year
February 1, 1968 | | PM 11:30 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | |
| male | white | January 20, 1909 | | | 59 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Maryland | USA | | | Baltimore | | Maint. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | |
| Towson | St. Joseph Hospital | | Balto. Civic Center | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER | | | | |
| Maryland | | Baltimore | | 1536 Abbottston St. | | | | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Last |
| Christian Kampes | | | | | Katherine Krietler | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give year or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | |
| No | | | | Mrs. Catherine A. Kampes-- Same | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Broncho-pneumonia of left lung</u> | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bronchogenic carcinoma of right lung.</u> | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | State |
| 22a. I certify that (X) (this hospital) attended the deceased from February 1, 1968, to February 19, 68, that (X) (we) last saw the deceased alive on February 1, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | |
| Lawrence F. Misanik, M.D. | | February 2, 1968 | | 7620 York Rd., Towson, Md. 21204 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | 2/5/68 | | Parkwood Cemetery | | Baltimore Co., Maryland | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Leonard J. Ruck Inc. | | 5305 Harford Rd. | | FEB 6 2 1968 | | Charles Judge | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)
30M REV 1/68

MD235

2223

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | |
|--|-----------------------------|--|--|---|--|--|--|
| 1 DECEASED-NAME
(Type or print) | | First Middle Last | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Alfred | | K A R E | | February 15, 1968 | | 7:50 AM | |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | |
| Male | White | December 20, 1888 | | 79 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a BIRTH-PLACE (State or foreign country) | 7b CITIZEN OF WHAT COUNTRY? | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | |
| Estonia | Estonia | | | Baltimore, Md | | | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) | | 12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| Towson | | ST. JOSEPH HOSPITAL | | Caretaker | | Hospital | |
| 13a U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE | | 13b CITY OR TOWN | | 13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER | |
| Maryland | | Balto. | | | | 7620 York Rd., | |
| 14 FATHER'S NAME | | 15 MOTHER'S MAIDEN NAME | | | | | |
| Jaan | | Kare | | Tiin Tint | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT | | Address | |
| No | | 213-30-2117 | | Mrs. Anna M. Kare | | (Same) | |
| 18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute massive hemorrhage | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Rupture of abdominal aortic aneurysm. | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 4 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY HOUR A.M. Month Day Year 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) | | | |
| 2d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING ETC) | | 21f LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from 2/13/1968, to 2/15/1968, that (X) (we) last saw the deceased alive on 2/15/1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (Type) | | | |
| Reynaldo Orjuela-Gomez, M.D. | | February 15, 1968 | | 7620 York Rd., Towson, Md. 21204 | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | |
| Burial | | 2/19/68. | | Gardens of Faith Cemetery | | Baltimore, Md. | |
| 24 FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Leonard J. Ruck, Inc. Balto. Md. | | 21214 | | FEB 16 1968 | | J. Charles Judge | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02224

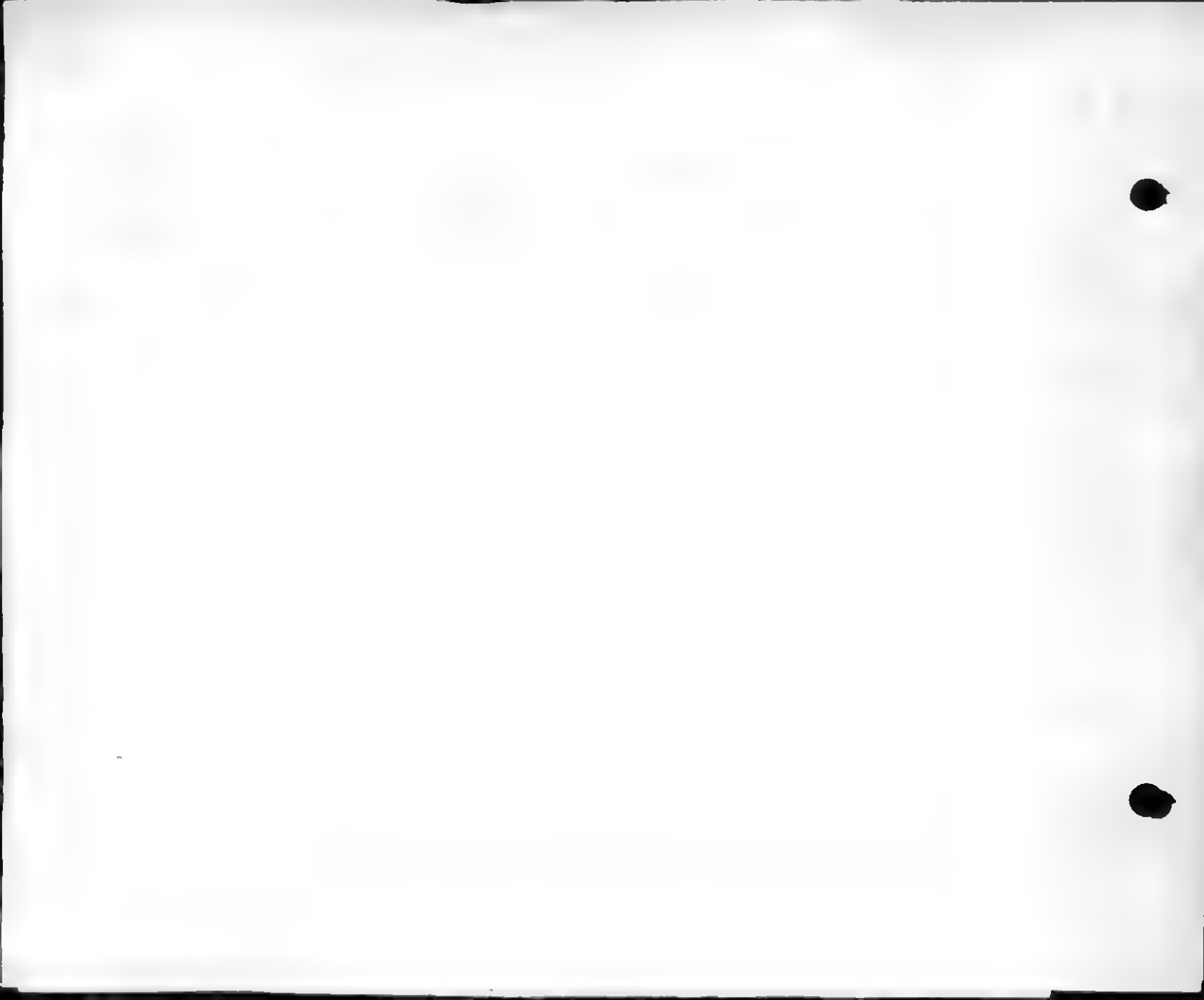
| | | | |
|--|-----------------------------|---|---|
| 1. NAME OF DECEASED
(Type or Print)
ELIZABETH C. KELLER | | 2. DATE AND HOUR OF DEATH
2-22-68 11:36 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Balto Co
2 Thicket Road | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland
C. CITY OR TOWN Baltimore
E. STREET AND NUMBER 2 Thicket Road
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9-15-1876 |
| 9. AGE (in years last birthday)
91 | | 10. CITIZEN OF WHAT COUNTRY?
USA | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
John Smith | | 14. MOTHER'S MAIDEN NAME
Charlotte Clemens | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
- | 17. INFORMANT
Mrs. Harry W. Wright |
| ADDRESS
Above | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Anterior Coronary Vascular Disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF

(B) DUE TO, OR AS A CONSEQUENCE OF

(C) | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1953 to 2/22 1968
that (I) (we) last saw the deceased alive on 2/19/68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
Thomas L. Worsley
DEGREE | | 23B. DATE SIGNED
2/23/68 | |
| 23C. PHYSICIAN'S NAME (Type)
Thomas L. Worsley M.D.
DEGREE | | 23D. ADDRESS
6505 York Road, Balto., Md. 21212 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
2-26-68 | 24C. NAME OF CEMETERY or CREMATORY
Parkwood | 24D. LOCATION (City, town, or county) (State)
Parkville Md. |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 28 1968 | | 25B. NAME OF REGISTRAR
Charles Judge | |
| 25C. FUNERAL DIRECTOR
H.W. Jenkins & Sons Co. | | ADDRESS
4905 York Rd. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 are to be retained by the funeral director.



MDARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

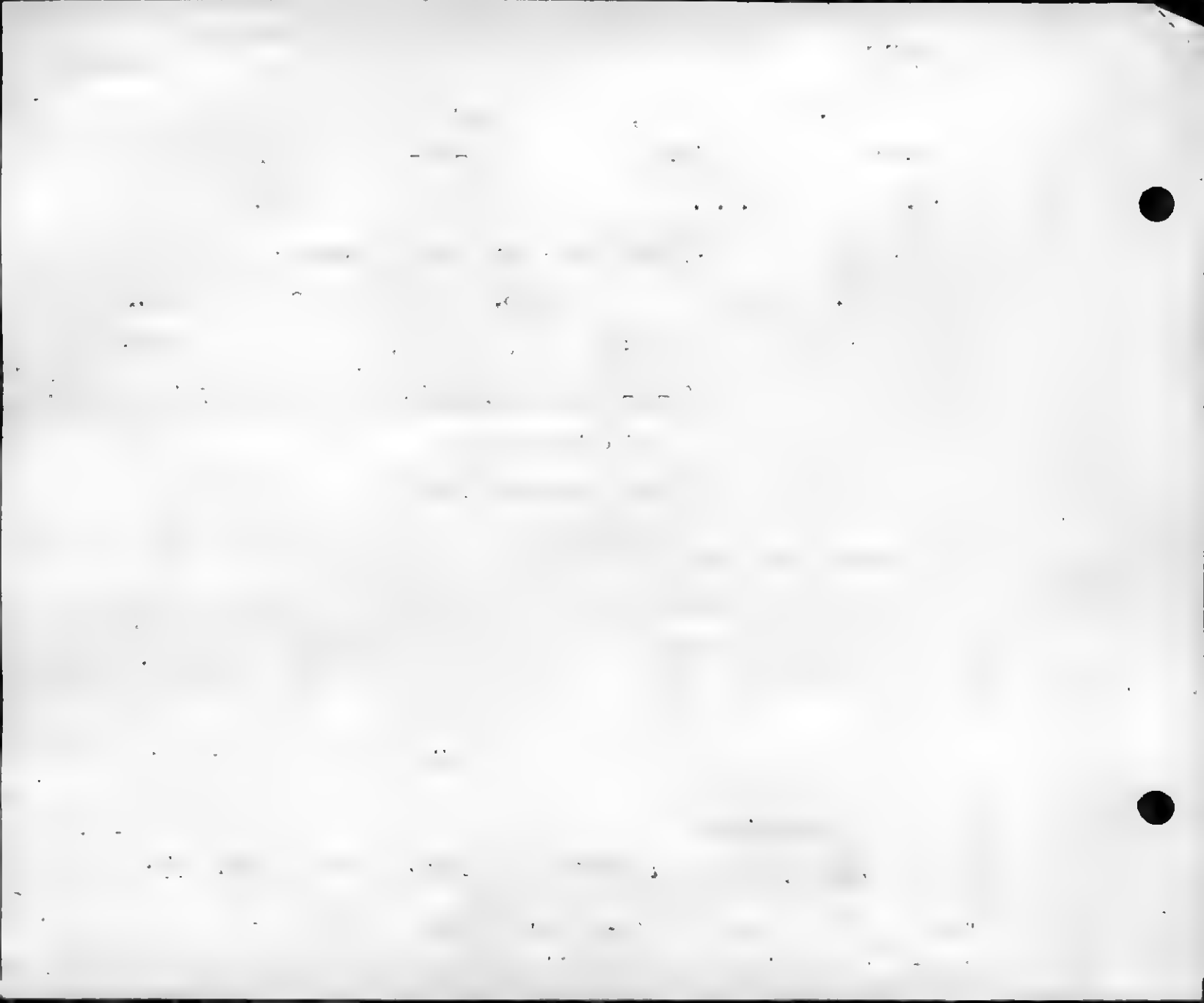
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02221

| | | | | | | | | |
|--|-----------------|--|---------|--|-------------------------------------|---|-------------------|--|
| 1 DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR
7 P M | |
| Edna | | E. | Kennard | 2 Month 2 Day Year 1968 | | | | |
| 3 SEX
Female | 4 RACE
White | 5 DATE OF BIRTH
4-13-80 79 | | 6 AGE (in years last birthday)
87 88 YRS. | | 7 UNDER 1 YEAR
MONTHS DAYS | | |
| 7a. BIRTHPLACE (State or foreign country)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH
Baltimore Md. | | |
| 10 CITY OR TOWN OF DEATH
Catonsville | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Spring Grove State Hosp | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if admission)
STATE Md. | | 13b. COUNTY
C | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET AND NUMBER
2207 Langley St. | | 14. FATHER'S NAME
First Middle Last
Unknown Arbenna Bossen/ | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Unknown Edna /Malipenny | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
220-05-2321A | | 17. INFORMANT
Andrew Birmingham Address 2207 Langley St | | Patient/Record/SPRING GROVE/STATE HOSP | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cardiac insufficiency
DUE TO, OR AS A CONSEQUENCE OF
(b) Anemia of unknown cause
DUE TO, OR AS A CONSEQUENCE OF
(c) Cardiac arrest
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (this hospital) attended the deceased from Sept 26, 1968, to Feb 21, 1968, that (I) (we) last saw the deceased alive on Feb 21, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
Narciso Aristigueta | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2-22-68 | | |
| 22d. PHYSICIAN'S NAME (Type)
NARCISO ARISTIGUETA | | | | 22e. ADDRESS
SPRING GROVE STATE HOSP. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
2/24/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Memorial Cem | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Md. | | |
| 24. FUNERAL DIRECTOR
Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | | 25a. REC'D BY REGISTRAR
DATE FEB 26 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles J. ... | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



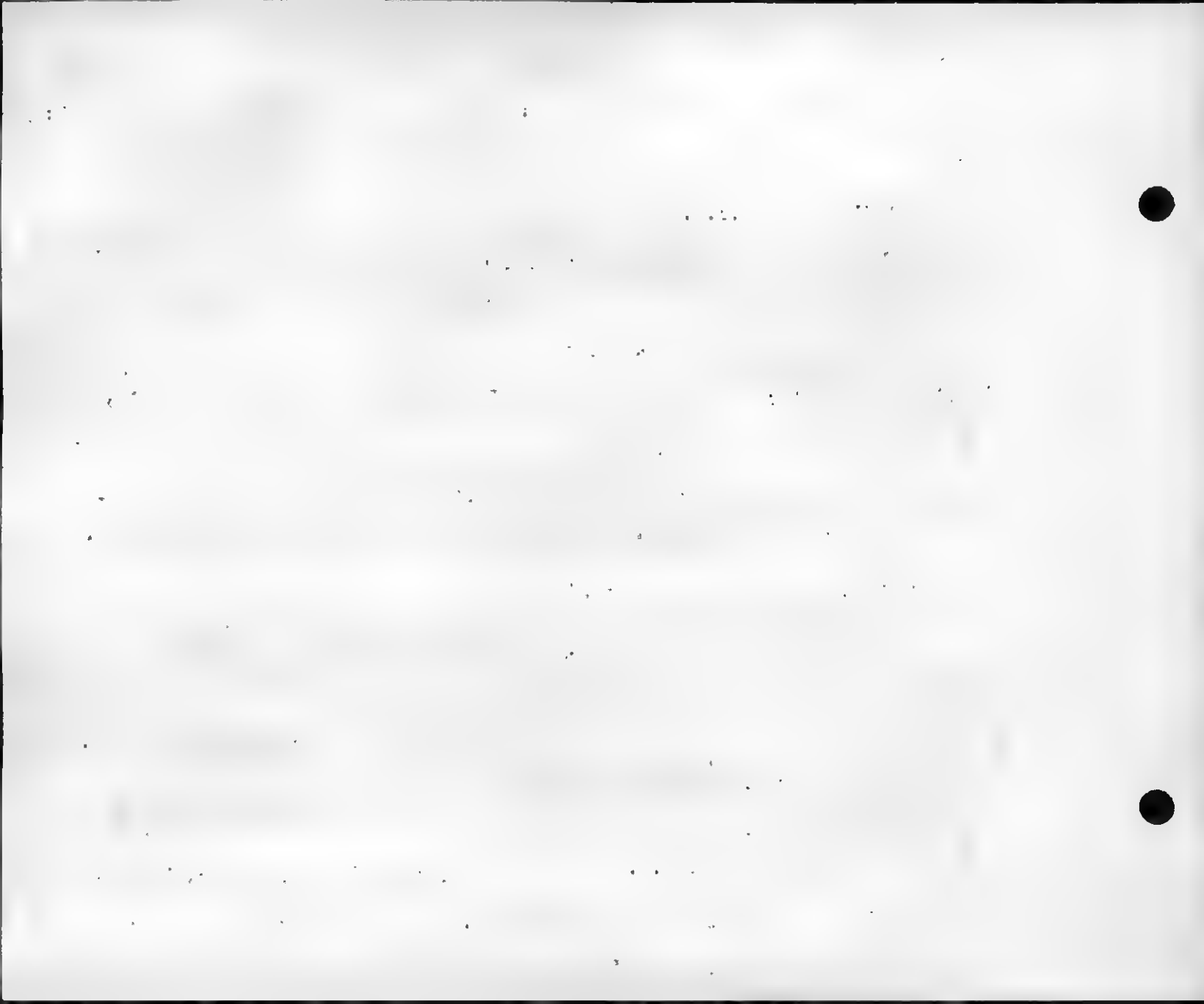
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VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|------------------------------------|--|--|--|
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| JOHN | | | ARNOLD | | | KENNEDY | | | FEBRUARY 17 1968 10:35 AM | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | |
| MALE | | | WHITE | | | 9/20/94 | | | 73 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | |
| MARYLAND | | | U.S.A. | | | BALTIMORE | | | Md | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| FORT HOWARD | | | HOSPITAL VETERANS ADMINISTRATION | | | YARD CLERK | | | RAILROAD | | |
| 13a. U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| MARYLAND | | | BALTIMORE | | | 1248 WILLIAMS STREET | | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | |
| JOHN H KENNEDY | | | JANE HOPKINS | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO | | | 17. INFORMANT | | | Address | | |
| YES WW I | | | 705 05 6103 | | | CLINICAL RECORDS, VA HOSP, FT HOWARD, MD | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | hours | |
| IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | days | |
| (b) CEREBRAL INFARCT, RECENT | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | years | |
| (c) ARTERIOSCLEROSIS | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| CIRRHOSIS OF LIVER, LAENNEC'S TYPE | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION | | | City or Town County State | | |
| | | | | | | Street or R.F.D. No | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from 2/1/68, 19, to 2/17/68, 19, that (A) (we) last saw the deceased alive on 2/17/68, 19, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | 22c. DATE SIGNED | | | |
| MARIO J. QUIROS, M.D. | | | | | | | | 2/18/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | 22e. ADDRESS | | | |
| MARIO J. QUIROS, M.D. | | | | | | | | VA HOSPITAL, FORT HOWARD, MARYLAND | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | | 2/20/68 | | | LOUDON PARK CEMETERY | | | BALTIMORE MD | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| MCCULLY FUNERAL HOME, 130 E FORT AVE, BALTO, MD | | | | | | DATE FEB 19 1968 | | Charles J. [Signature] | | | |

MEDICAL CERTIFICATION

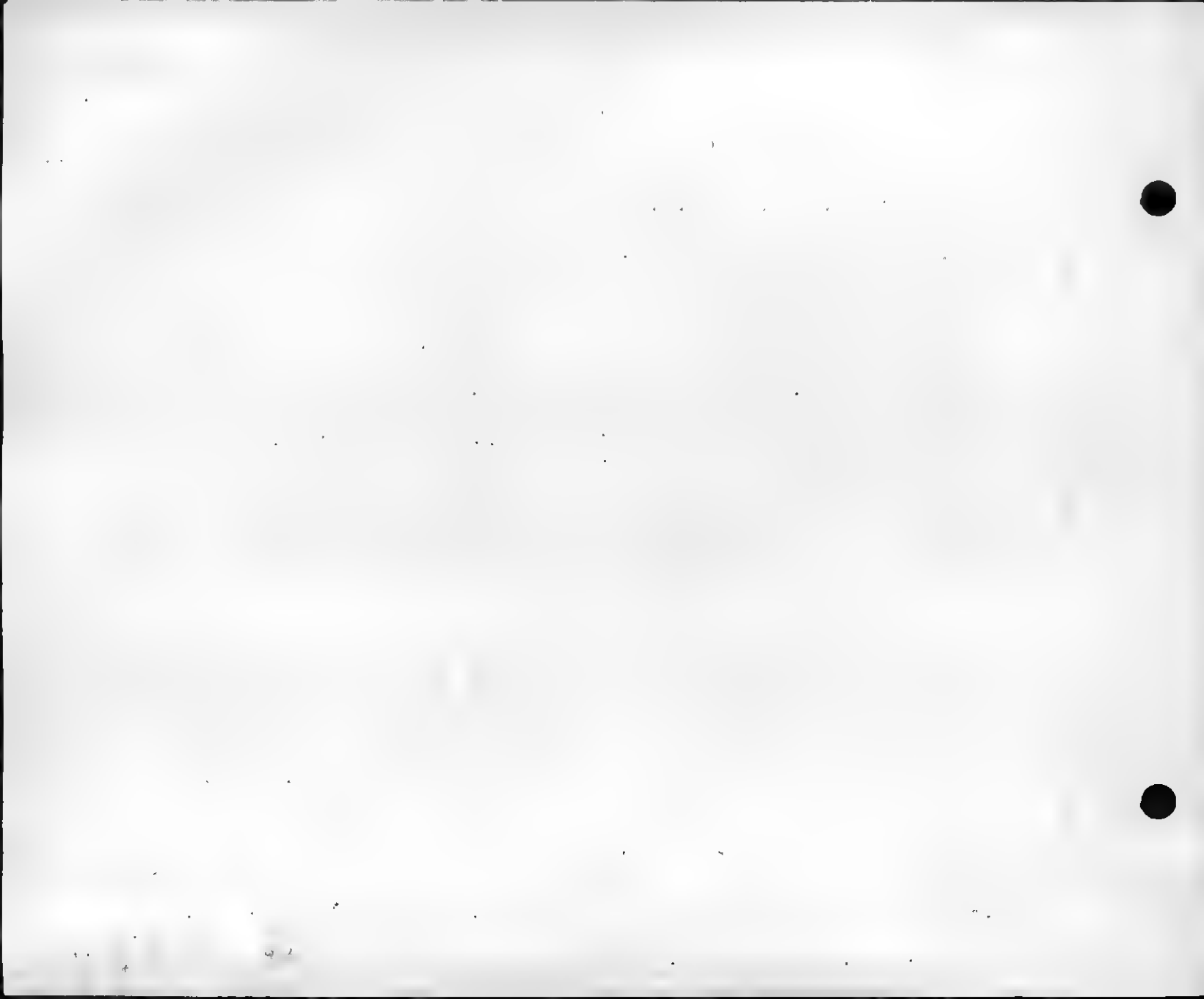


FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--------|---|---|---|---|---|---|----------------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1 DECEASED NAME
(Type or Print) | | First | | Middle | | Last | | 2a DATE KNOWN OF DEATH | |
| JOHN | | I. | | KERCHERVILLE | | | | Month Day Year
2/25 19 68 | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | | 6 AGE (In years last birthday) | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN | | 2b HOUR |
| male | white | 8/7/94 | | 72 | | | | | 7:45 P. M. |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Montgomery Co., Md. | | U.S.A. | | | | Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| Ft. Howard | | | Vet. Adm. Hospital | | | unh | | | |
| 13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER |
| Maryland | | | | | Baltimore | | | | 9 S. Poppleton Street |
| 14 FATHER'S NAME | | | 15 MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| George Kercherville | | | Margaret Unknown | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) | | | 16b SOCIAL SECURITY NO | | 17 INFORMANT ADDRESS | | | | |
| Yes | | | W.W.I | | Mrs. Rose Marie Dominick | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bilateral Abscess Forming Pneumonia Complicating | | | | | | | | | |
| Cerebral Injury | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> | | | 21b TIME OF INJURY Month, Day, Year | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | |
| CAUSE OF DEATH | | | UNKN P.M. 11/6/ 19 67 | | Subj. beaten about head (found) | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f LOCATION Street or R.F.D. No. | | City or Town | | County | State |
| | | home | | | | Baltimore, | | Maryland | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | | M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED | |
| EXAMINER'S NAME (Type) | | | Werner U. Spitz, M.D. | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 2/27/68 | |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | ADDRESS (Street, city, town, or county) | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | | | |
| Burial | | 2/29/68 | | Baltimore National | | Baltimore, Md. | | | |
| 24 FUNERAL DIRECTOR | | | ADDRESS | | | 25a REC'D BY REG STRAR | | 25b REG STRAR'S SIGNATURE | |
| Joseph N. Zannino | | | 263 S. Conkling Street | | | FEB 27 1968 | | Charles Judge | |

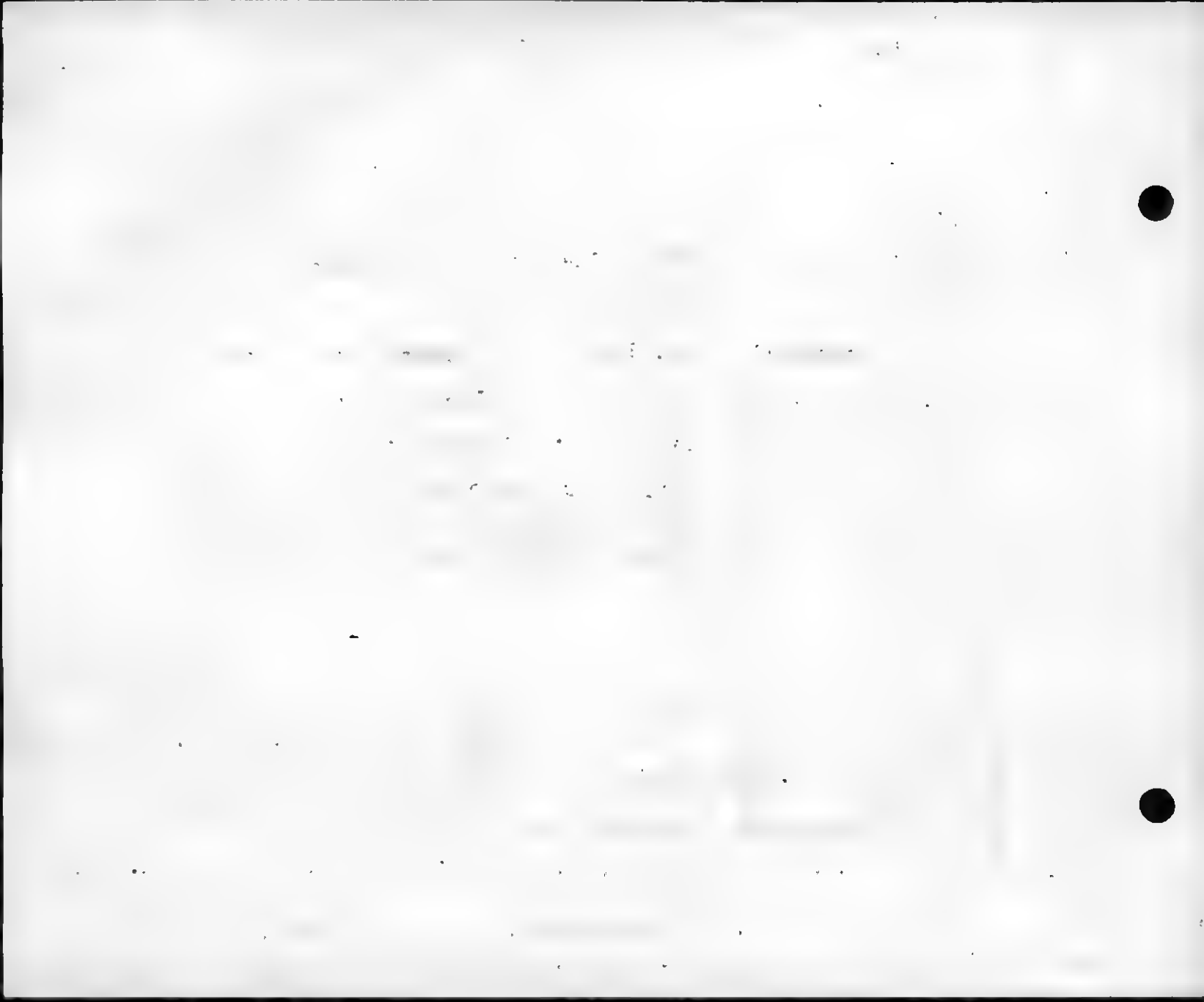


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
|--|--|--|------------------------|---|--|---|---|---|---|--|---|-------------------------|
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
MARION | | Middle
V. | | Last
KING | | 2a. DATE OF DEATH
Month
February Day
3 Year
1968 | | | 2b. HOUR
noon |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
September - , 1885 | | | 6. AGE (In years last birthday)
82 YRS. | | 7. UNDER YEAR
MONTHS
3 DAYS
12 HOURS
00 MIN | | 8. UNDER 24 HRS
HOURS
12 MIN | |
| 7a. BIRTHPLACE (State or foreign country)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore 4 Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)
St. Joseph Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Homemaker | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
918 East Lake Ave. 21212 | | | | |
| 14. FATHER'S NAME
First
Unknown Middle
Charles H. Last
Bray | | | | 15. MOTHER'S MAIDEN NAME First
Unknown Middle
Mary A. Last
Lee | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) (If yes give war or dates of service)
no | | | | |
| 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT
Hospt. Records, | | | | Address | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) HYPERTENSIVE ENCEPHALOPATHY
DUE TO, OR AS A CONSEQUENCE OF
(b) GENERALIZED ARTERIOSCLEROSIS
DUE TO, OR AS A CONSEQUENCE OF
(c) 4
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
224 | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY)
OFFICE BUILDING, ETC. | | 21f. LOCATION
Street or R.F.D. No
City or Town
County
State | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from December 30 1967 , to February 3 1968 , that (x) (we) last saw the deceased alive on February 3, 1968 , and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
Dr. Gualberto C. Gokim, Jr. DEGREE
ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | | | | | | | 22c. DATE SIGNED
February 3, 1968 | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Dr. Gualberto C. Gokim, Jr. | | | | | | | | 22e. ADDRESS
7620 York Road, Baltimore, Md. 21204 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
2/6/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cem. | | 23d. LOCATION (City or Town)
Balto. | | 23e. REGISTRAR'S SIGNATURE
Mitchell-Wiedefeld | | | | |
| 24. FUNERAL DIRECTOR
Mitchell-Wiedefeld Home-6500 York Rd. 21212 | | 25a. REC'D BY REGISTRAR
DATE FEB 8 1968 | | 25b. REGISTRAR'S SIGNATURE
Judge | | | | | | | | |



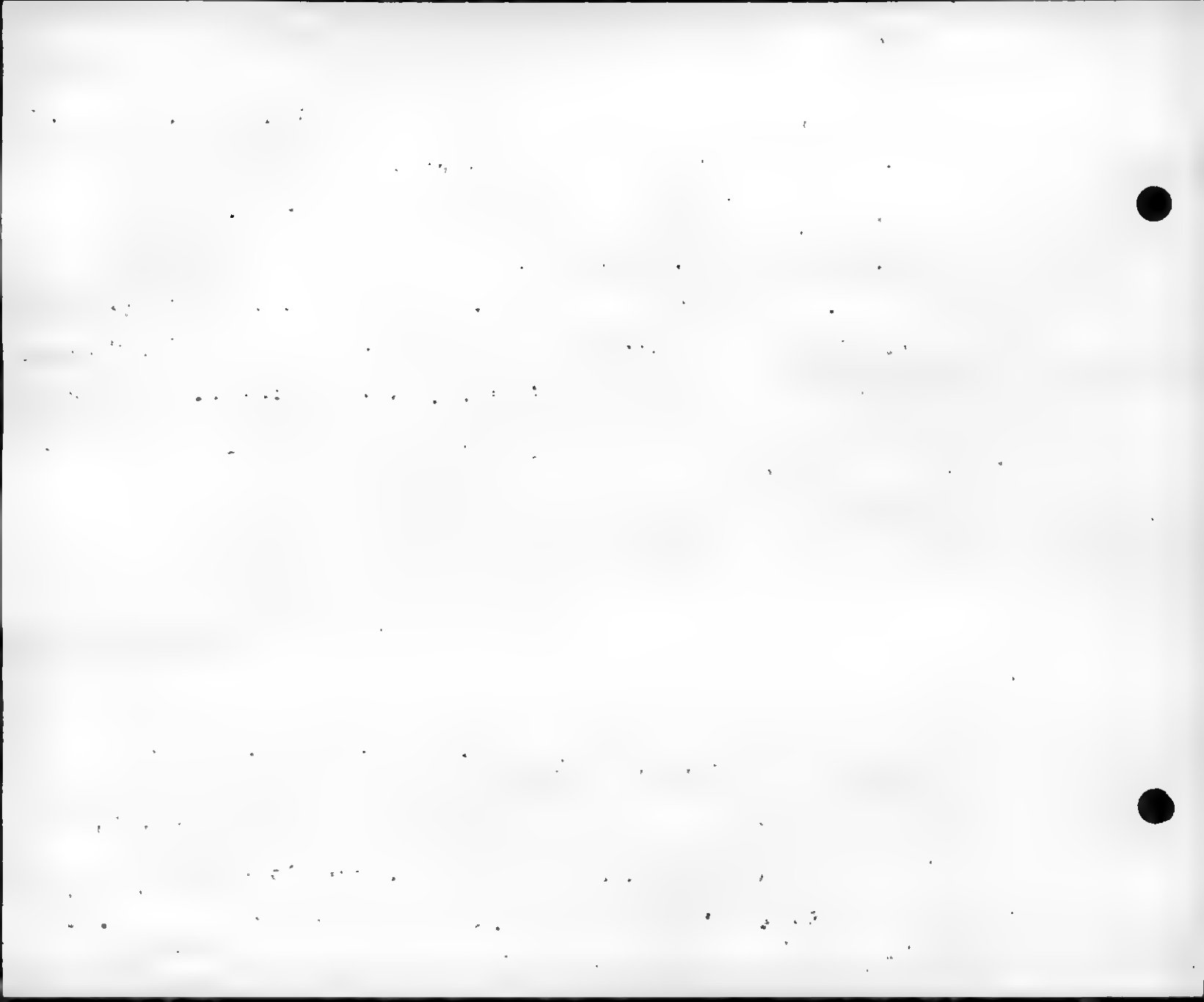
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | |
|--|--|--|---|
| 22241 | | 2229 | |
| 1 DECEASED NAME
(Type or print) | | First | Middle |
| MARY | | G. | KING |
| 2a. DATE OF DEATH | | Month | Day |
| Feb. | | 24 | 1968 |
| 2b. HOUR | | 4:50 PM | |
| 3. SEX | 4 RACE | 5. DATE OF BIRTH | |
| Female | White | June 6, 1934 | |
| 6. AGE (In years last birthday) | 7. BIRTHPLACE (State or foreign country) | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 33 YRS. | Md. | | 9. COUNTY OF DEATH |
| | U.S.A. | | Balto. |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) |
| Balto. | St. Joseph Hospital | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Md. | Balto. | Balto. | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | |
| First | Middle | First | Middle |
| WALTER | Bell's | CATHERINE | Morseberger |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | |
| | | | |
| 17. INFORMANT | | Address | |
| FRANCIS D. KING | | 104 Rosewood Ave 21228 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hodgkins Disease Terminal</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | |
| | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | |
| | | | |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | |
| | | | |
| 21f. LOCATION | | 21g. LOCATION | |
| Street or R.F.D. No | | City or Town | |
| | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 22, 1968</u> , to <u>Feb. 24, 1968</u> , that (I) (we) last saw the deceased alive on <u>Feb. 24, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | |
| <i>Antonio de Leon M.D.</i> | | Feb. 24, 1968 | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | |
| Antonio de Leon M.D. | | St. Joseph Hospital | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | |
| BURIAL | | 2/28/68 | |
| 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | |
| BALTO. NATIONAL CEM. | | BALTO. Md | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | |
| E.S. Mac Nabbs | | FEB 29 1968 | |
| ADDRESS | | 25b. REGISTRAR'S SIGNATURE | |
| Catonsville Md | | <i>Charles J...</i> | |



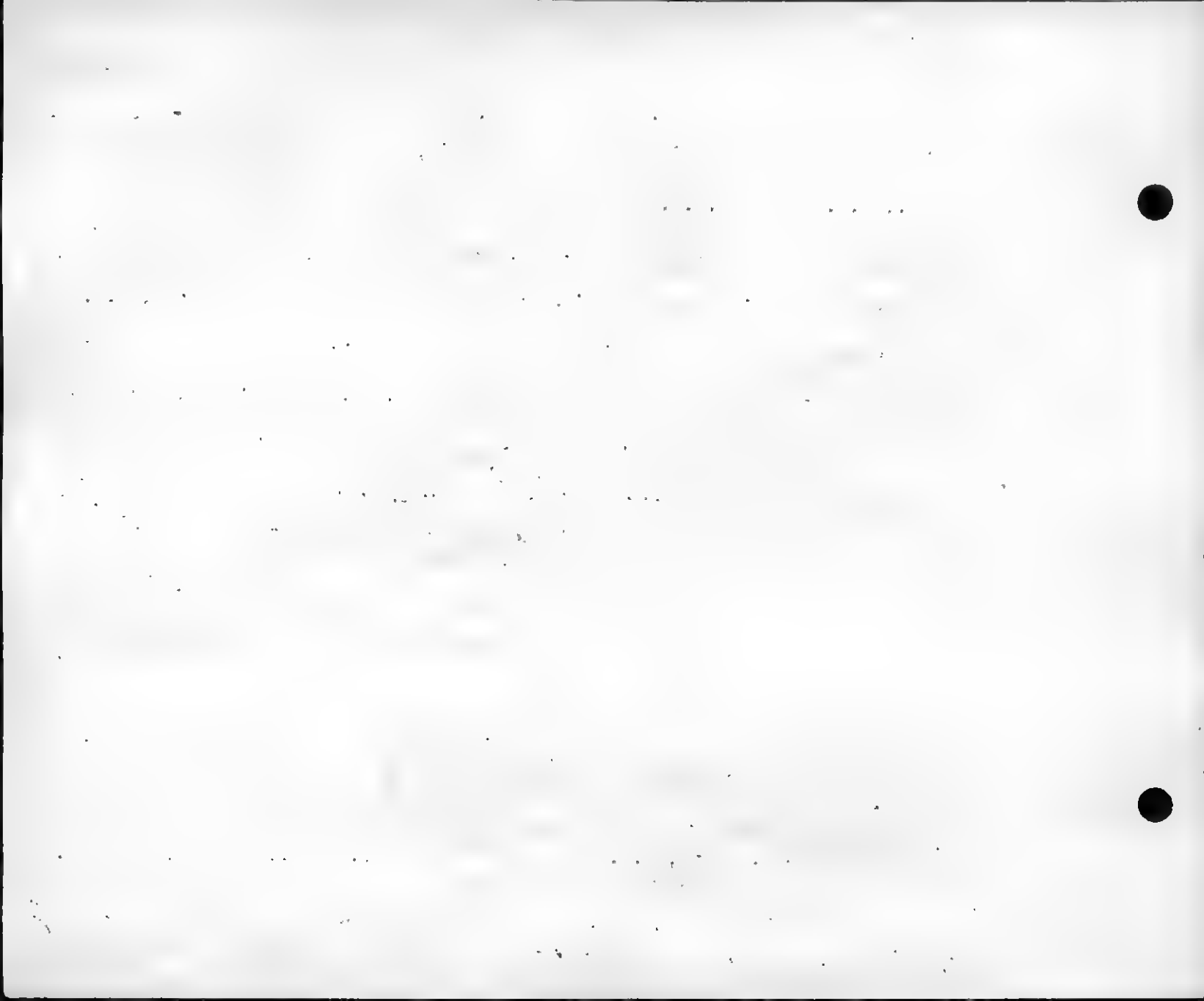
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1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | | |
|---|------------------------------|--|--|--|------------------------------------|--|-----------------------------|---|--|
| 1 DECEASED NAME
(Type or print) | | First | Middle | Last | 2a DATE OF DEATH
Month Day Year | | 2b HOUR
M | | |
| Julia | | May | | KIRBY | 2 Month 2 Day 14 Year 68 | | 7:10 AM | | |
| 3 SEX | 4 RACE | | 5. DATE OF BIRTH | | 6 AGE (In years lost-birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | |
| Female | White | | 11/18/04 | | 65 YRS | | IF UNDER 24 HRS HOURS M.N. | | |
| 7a BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | | 8- MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | Md | | |
| Wash., D.C. | U.S.A. | | | | Baltimore | | | | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a USUAL OCCUPATION (Kind of work done during most of work ng. life, even if ret red) | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| Owings Mills | | Rosewood State Hospital | | dependent | | none | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER | |
| Maryland | | Prince George | | St. Pleasant | | | | 526-69th Street, N.E. | |
| 14 FATHER'S NAME | | 15 MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | First Middle Last | | | | | | | |
| Joseph Kirby | | Katherine Cage | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO | | 17 INFORMANT Address | | | | | |
| no -- | | none | | Rosewood Records, Owings Mills, Maryland | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Neurotizing bronchial pneumonia</u>
4441
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) <u>Multiple Cerebral infarctions</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Aortic + Common Carotid thrombosis</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 days,
1 1/2 yrs,
1 1/2 yrs. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Severe mental retardation etiology undetermined, congenital</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. ALTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County State | |
| 22a. I certify that (this hospital) attended the deceased from <u>4/15</u> , 19 <u>59</u> , to <u>2/14</u> , 19 <u>68</u> , that (X) (we) lost saw the deceased alive on <u>2/14</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (did not) view the body after death | | | | | | | | | |
| 22b SIGNATURE | | 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | | 22e. DATE SIGNED | | 22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | |
| <u>Richard A. Jones</u> | | Richard A. Jones, M.D. | | Rosewood St. Hosp., Owings Mills, Md. | | 2/14/68 | | | |
| 23a BURIAL-CREMATATION, REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| <u>131-11th St. S.E. D.C.</u> | | <u>1-16-17-18</u> | | <u>131-11th St. S.E. D.C.</u> | | <u>131-11th St. S.E. D.C.</u> | | | |
| 24 FUNERAL DIRECTOR | | 25a REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| <u>131-11th St. S.E. D.C.</u> | | DATE FEB 16 1968 | | <u>131-11th St. S.E. D.C.</u> | | | | | |

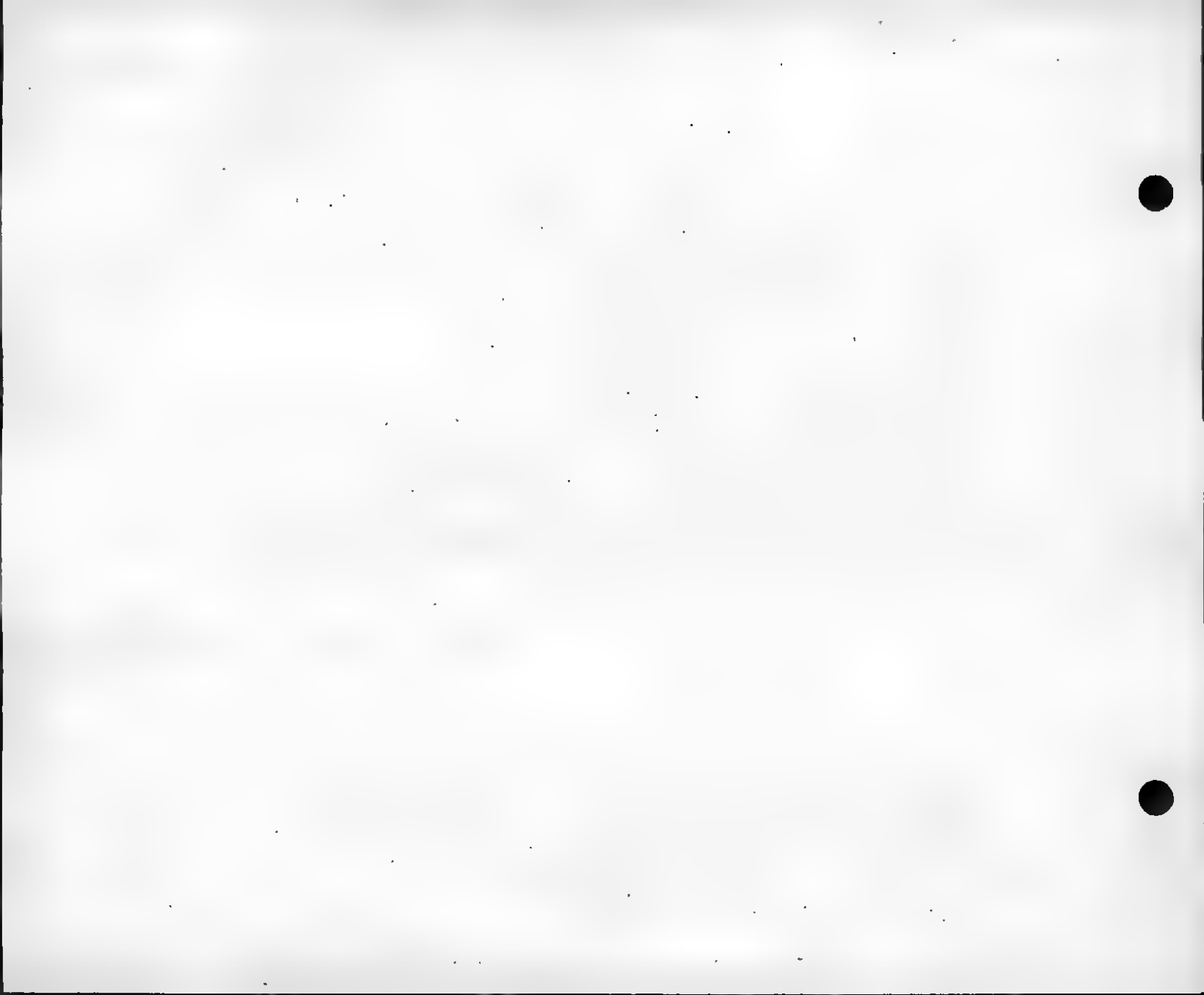


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-100-1. This may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MAYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|---------------------|---|--|---|--|---|---|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1 DECEASED NAME
(Type or Print) Viola B. Kolb | | | 2a DATE KNOWN OF EST DEATH MATED 2-3 1968 | | | 2b HOUR 11:30 PM | | | |
| 3 SEX Female | 4 RACE Cauc. | 5 DATE OF BIRTH 5/6/16 | 6 AGE (In years last birthday) 51 YRS | 7 UNDER YEAR MONTHS 0 DAYS 0 | 8 IF UNDER 24 HRS HOURS 0 MIN 0 | 2c DATE PRONOUNCED DEAD Month 2 - Day 3 - Year 68 | | | 2d HOUR 1:00 PM |
| 7a BIRTHPLACE (State or foreign country) MARYLAND | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore County | | | |
| 10 CITY OR TOWN OF DEATH Baltimore County | | | 11 NAME OF HOSPITAL OR INSTITUTE (If not in hospital, give street address) Hicksville Killeen Co. | | | 2a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Saleswoman | | 12b. KIND OF BUSINESS OR INDUSTRY Dept. Store | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE MARYLAND | | | 13b COUNTY Baltimore County | | 13c CITY OR TOWN Baltimore | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER 521 South 46th St. |
| 14 FATHER'S NAME First Guy Middle Hilditch Last | | | 15 MOTHER'S MAIDEN NAME First Mellie Middle Lutz Last | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) No | | | 16b. SOCIAL SECURITY NO. 217-16-4357 | | 17 INFORMANT Joseph Kolb | | ADDRESS 521 South 46th St. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 410.9
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Cornary Occlusion
(b) A-S-C-L - A. disease
DUE TO, OR AS A CONSEQUENCE OF
(c)
DUE TO, OR AS A CONSEQUENCE OF
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 421 | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION 4/10/68 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED APR | | | 20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b TIME OF INJURY Month, Day, Year 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 8) | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> OR NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE M.B. Davis | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b DATE SIGNED 2/4/68 | | | |
| EXAMINER'S NAME (Type) M.B. Davis MD | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | 23b DATE 2/7/68 | | 23c NAME OF CEMETERY OR CREMATORY Catholic Cemetery | | 23d LOCATION (City or Town) (County) (State) Baltimore, Maryland | | |
| 24 FUNERAL DIRECTOR Wm Cook-Brooks Inc. | | | ADDRESS Baltimore, Md. 21201 | | | 25a REC'D BY REGISTRAR FEB 6 1968 | | 25b REGISTRAR'S SIGNATURE Charles Judge | |

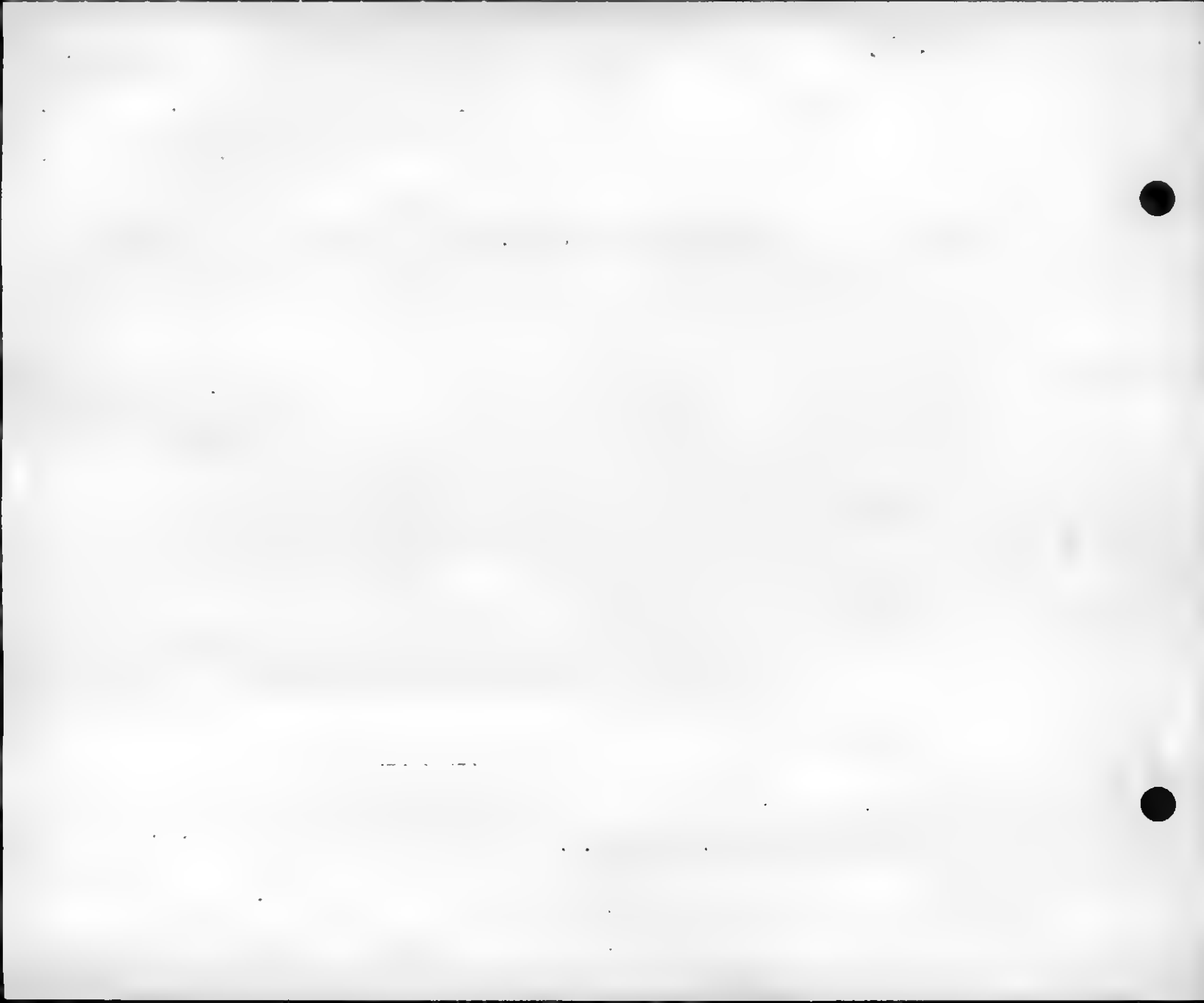


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1003. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|---|--------|------------------|---|--------------------------------|--|--|---|---------------------------|-----------------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | |
| 1 DECEASED NAME (Type or Print) | | | First | | Middle | | Last | | | |
| FREDERICK | | | G. | | KRAFT | | | III | | |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | | 6 AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | | 2a DATE KNOWN OF ESTI-DEATH MATED | |
| Male | White | 1954 | | 13 YRS | | | | | Month Day Year 1968 2:15 PM | |
| 7a BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | |
| MD. | | | USA | | | | | Baltimore Md | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) | | | 12b KIND OF BUSINESS OR INDUSTRY | |
| CATONSVILLE | | | Rolling Rd. South of Edmondson Avenue | | | STUDENT | | | SCHOOL | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER | |
| Maryland | | | Baltimore | | CATONSVILLE | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 325 Whitfield Road | |
| 14. FATHER'S NAME | | | First | | Middle | | Last | | | |
| FRED | | | G. | | KRAFT, JR | | | MARY JO RICE | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or UNKNOWN) | | | 16b SOC. SEC. SECURITY NO. | | 17. INFORMANT | | | ADDRESS | | |
| | | | | | Dr. Fred B. Kraft Jr. | | | 325 Whitfield Rd. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxia due to aspiration of gastric content | | | | | | | | | | |
| 16.9 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | | | | | | | |
| 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | |
| 20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b TIME OF INJURY Month, Day, Year HOUR A.M. | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| Unknown | | | 2-4 1968 | | | Car struck telephone pole | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e PLACE OF INJURY (At home, farm, street factory, office building, etc.) | | | 21f LOCATION Street or R.F.D. No City or Town County State | | | | |
| | | | Street Rolling Rd. So. of Edmondson Ave | | | Balto. Md. | | | | |
| 22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE | | | EXAMINER'S NAME (Type) | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b DATE SIGNED | |
| Werner U. Spitz | | | M.D. | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | 2-4-68 | |
| | | | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | |
| | | | | | | ADDRESS (Street, city, town, or county) | | | | |
| 23a BURIAL, CREMATION REMOVAL (Specify) | | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | | | |
| Burial | | | 2-7-68 | | Catholic Cem. | | Baltimore Md. | | | |
| 24 FUNERAL DIRECTOR | | | ADDRESS | | | 25a REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | |
| Foley Company D.F.N. - Catonsville, Md | | | | | | FEB 8 1968 | | Charles Judge | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

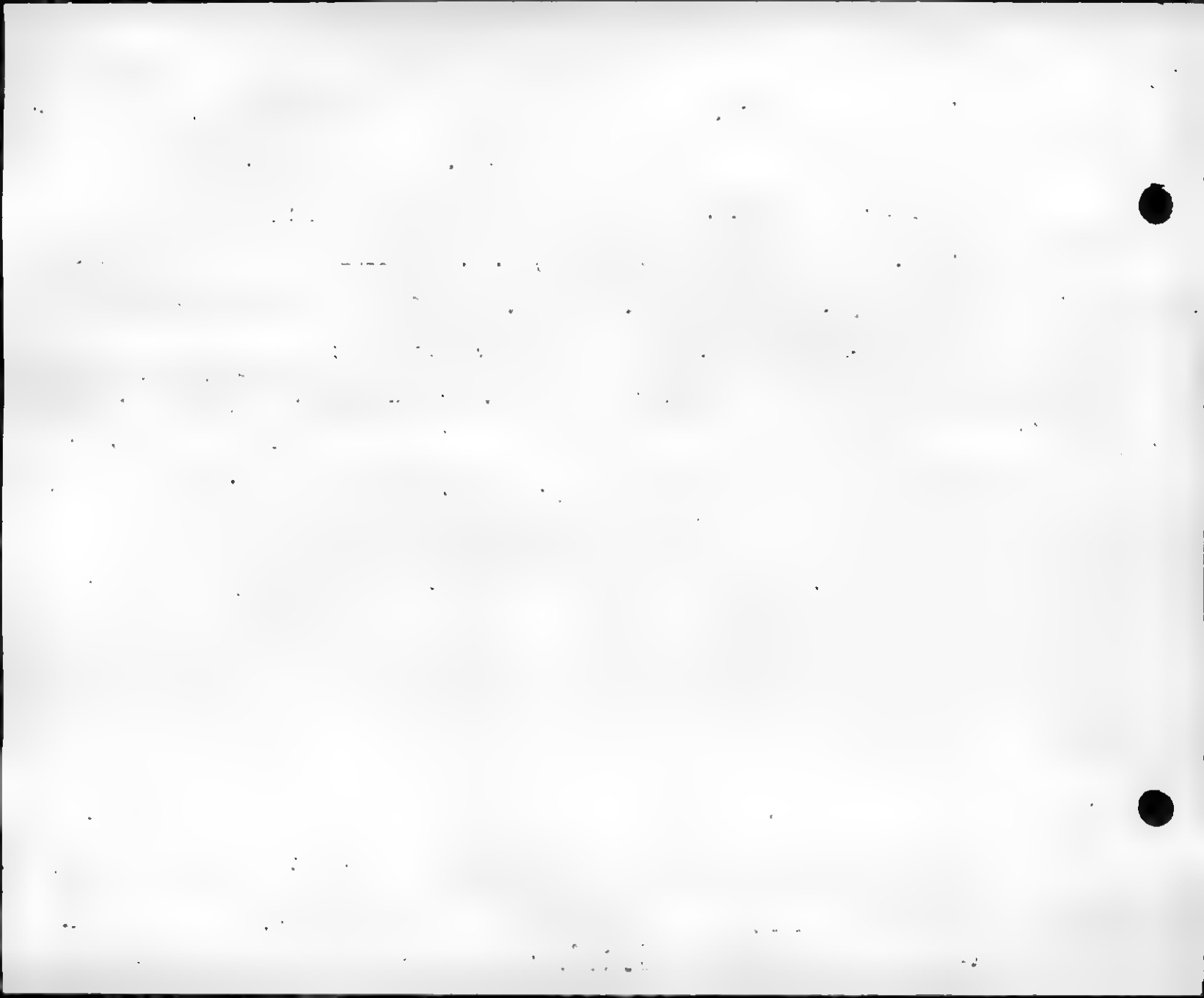
| | | | | | | | | |
|--|------------------------|--|--|---|--|---|---|--|
| 1 DECEASED NAME
(Type or Print)
BRIAN JOSEPH KUKLA | | | 2a. DATE KNOWN OF DEATH
Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year <input checked="" type="checkbox"/>
2/2/1968 | | | 2b. HOUR
12 A M | | |
| 3 SEX
male | 4 RACE
white | 5 DATE OF BIRTH
Dec. 12, 1967 | 6 AGE (In years last birthday)
1 YRS 1 MONTHS 21 DAYS | IF UNDER 1 YEAR
MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN <input type="checkbox"/> | | 2c. DATE PRONOUNCED DEAD
Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year <input checked="" type="checkbox"/>
February 2, 1968 | | 2d. HOUR
7:00 A M |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH
Baltimore | | |
| 10 CITY OR TOWN OF DEATH
Towson | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
St. Joseph's | | | 12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired.)
None | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE
Maryland | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME
First Frank Middle George Last Kukla | | | 15. MOTHER'S MAIDEN NAME
First Kathy Middle Marie Last O'Brien | | | 13e. STREET AND NUMBER
2418 Bridgehampton Apts. | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
No | | | 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT ADDRESS
Mr. Frank G. Kukla 2418 Apt F Bridgehampton Dr | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 444X Interstitial Pneumonitis (SDII)
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. _____ P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____ | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE
Werner U. Spitz, M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED
2/2/68 | | |
| EXAMINER'S NAME (Type) | | | ADDRESS (Street, city, town, or county) | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
2/3/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Cockeysville, Maryland | | |
| 24. FUNERAL DIRECTOR
Wm. Cook-Brooks Towson 1050 York Rd. 21204 | | | | 25a. REC'D BY REGISTRAR
FEB 9 1968 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles J. [Signature]</i> | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

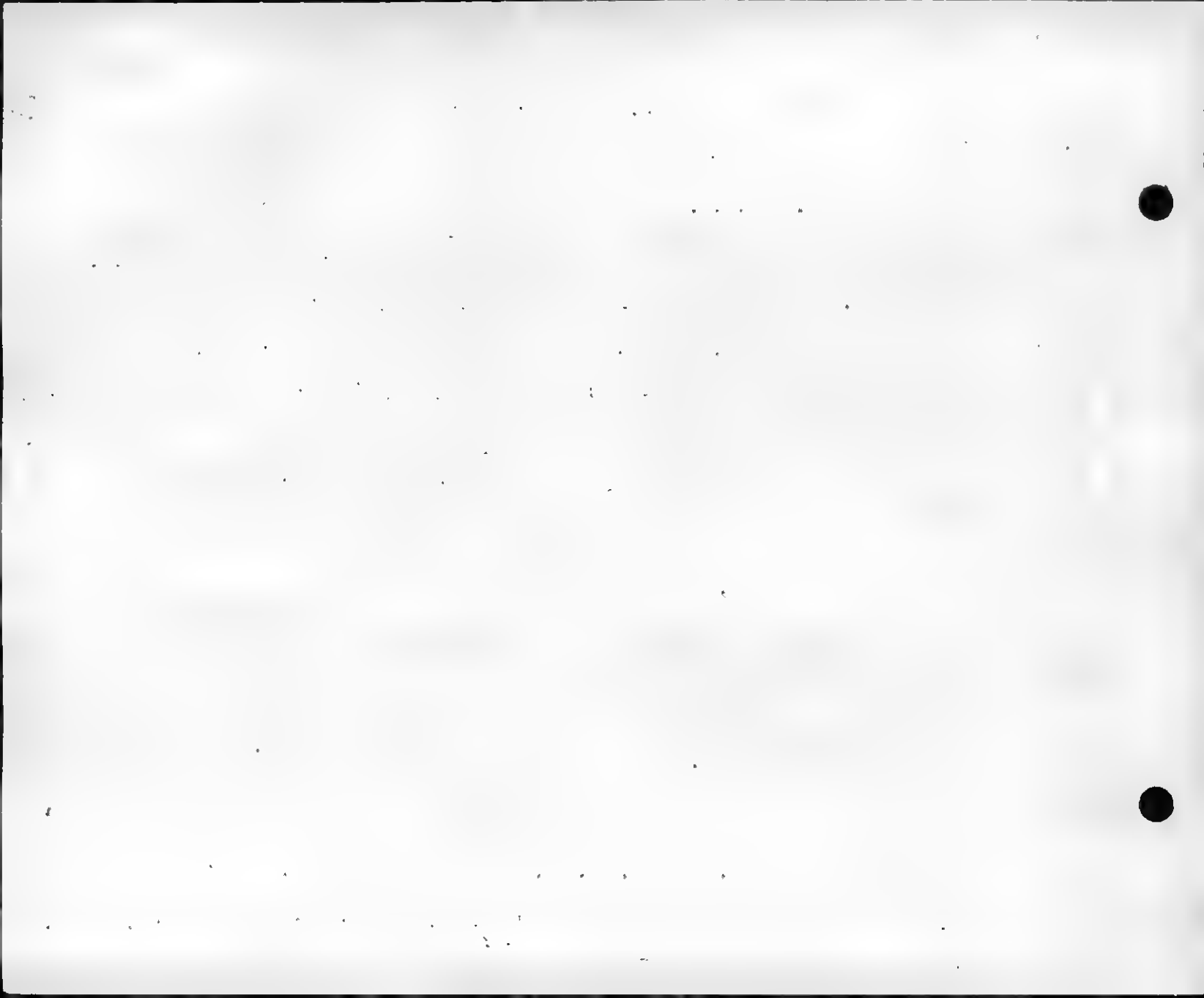
| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|---|--|--|--|--|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED NAME
(Type or print) Fannie Lambdin | | | First Middle Last | | | 2a. DATE OF DEATH
Month 2 Day 7 Year 68 | | | 2b. HOUR
8:30 AM | | |
| 3. SEX
Female | | | 4. RACE
W | | | 5. DATE OF BIRTH
Jan. 28, 1885 | | | 6. AGE (In years last birthday)
83 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Balto. Md | | |
| 10. CITY OR TOWN OF DEATH
Balto. | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Bloomsbury N. H. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
--- | | | 12b. KIND OF BUSINESS OR INDUSTRY
--- | | |
| 13a. USUAL RESIDENCE (Where deceased lived, admission) STATE
Maryland | | | 13b. COUNTY
Balto. | | | 13c. CITY OR TOWN
Balto. | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET AND NUMBER
4701 Dartford Avenue | | | 14. FATHER'S NAME First Middle Last
Charles WITZKE Lambdin | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Frances Lambdin | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown no (If yes give war or dates of service) | | |
| 16b. SOCIAL SECURITY NO
none | | | 17. INFORMANT
Mrs. Carroll Sparks, 4701 Dartford Avenue, Baltimore, Md. 21229 | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC C-V DISEASE
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) HYPERTENSIVE ART. SCLER. C-V DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) --- | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 YEARS
12 YEARS | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4. ACUTE VIRAL INFLUENZA & PNEUMONIA, LEFT BASE | | | | | | | | | | | |
| 9a. DATE OF OPERATION | | | 9b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 68 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY)
(OFFICE BUILDING, ETC) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/15 , 19 67 , to 2/7 , 19 68 , that (I) (we) last saw the deceased alive on 2/5 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Paul R. Ziegler MD | | | DEGREE MD | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | 22c. DATE SIGNED
2/8/68 | | |
| 22d. PHYSICIAN'S NAME (Type)
Paul Ziegler | | | 22e. ADDRESS
200 CHESTNUT HILL DR. ELICOTT CITY, MD. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
2-9-68 | | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill | | | 23d. LOCATION (City or Town) (County) (State)
Balto. Md. | | |
| 24. FUNERAL DIRECTOR
Witzke Funeral Directors, Balto., Md. 21229 | | | 25a. REC'D BY REGISTRAR
FEB 8 1968 | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|---|--|--|--|--|--|-------------------------------|--|--|---|--|-----------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME
(Type or print) | | | First
John | | | Middle
H. | | | Last
Lancaster | | | 2a. DATE OF DEATH
Month
2 Day
19 Year
1962 | | | 2b. HOUR
10:25 P.M. | | | | | | |
| 3. SEX
Male | | | 4. RACE
White | | | 5. DATE OF BIRTH
8-28-1905 | | | 6. AGE (In years
lost birthday)
62 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS | | | IF UNDER 24 HRS.
HOURS MIN | | | | | | |
| 7a. BIRTHPLACE (State or foreign
country)
Baltimore Co. | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Baltimore Md | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Perry Hall | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
4123 Cliffvale Rd | | | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Shovel operator | | | 12b. KIND OF BUSINESS OR
INDUSTRY
C. B. Temple | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before
admission) STATE
Md. | | | 13b. COUNTY
Baltimore | | | 13c. CITY OR TOWN
Perry Hall | | | 3a. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 3e. STREET AND NUMBER
21236
4123 Cliffvale Road | | | | | | | | | |
| 14. FATHER'S NAME
First
Charles | | | Middle
L. | | | Last
Lancaster | | | 15. MOTHER'S MAIDEN NAME
First
Emma | | | Middle
H. | | | Last
Borin | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
No | | | (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
217-07-3423 | | | 17. INFORMANT
Mrs. Carl S. Lancaster | | | Address
4123 Cliffvale Road | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> | | | | | | | | | | | | Immediate | | | | | | | | | |
| Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. | | | | | | | | | | | | (b) <u>Generalized Coronary Arteriosclerosis</u>
10 years | | | | | | | | | |
| (c) <u>Emphysema, Chronic Bronchitis</u> | | | | | | | | | | | | | | | | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | |
| 1. <u>Emphysema, Chronic Bronchitis</u> | | | | | | | | | | | | | | | | | | | | | |
| 9a. DATE OF OPERATION | | | 9b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No | | | City or Town | | | County | | State | | | | | | | |
| 22a. I certify that (I) (we) (did not) attended the deceased from July 3, 1962, to Feb. 19, 1968, that (I) (we) last
saw the deceased alive on Feb. 19, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Theodore E. Evans, M.D.</u> | | | | | | | | | | | | DEGREE
M.D. | | ATTENDING
PHYS. <input checked="" type="checkbox"/> | | MED.
DIRECTOR <input type="checkbox"/> | | STAFF
PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
2-20-68 | |
| 22d. PHYSICIAN'S
NAME (Type)
Theodore E. Evans, M.D. | | | | | | | | | | | | 22e. ADDRESS
9660 Belair Rd., 21236 | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | | 23b. DATE
2-23-1968 | | | 23c. NAME OF CEMETERY OR CREMATORY
St. Michael's Cemetery | | | 23d. LOCATION (City or Town)
Baltimore | | | (County)
Co. | | | (State)
Md. | | | | | | |
| 24. FUNERAL DIRECTOR
<u>Lassahn Funeral Home</u> | | | | | | | | | | | | ADDRESS
7401 Belair Rd. | | 25a. REC'D BY REGISTRAR
DATE FEB 23 1968 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

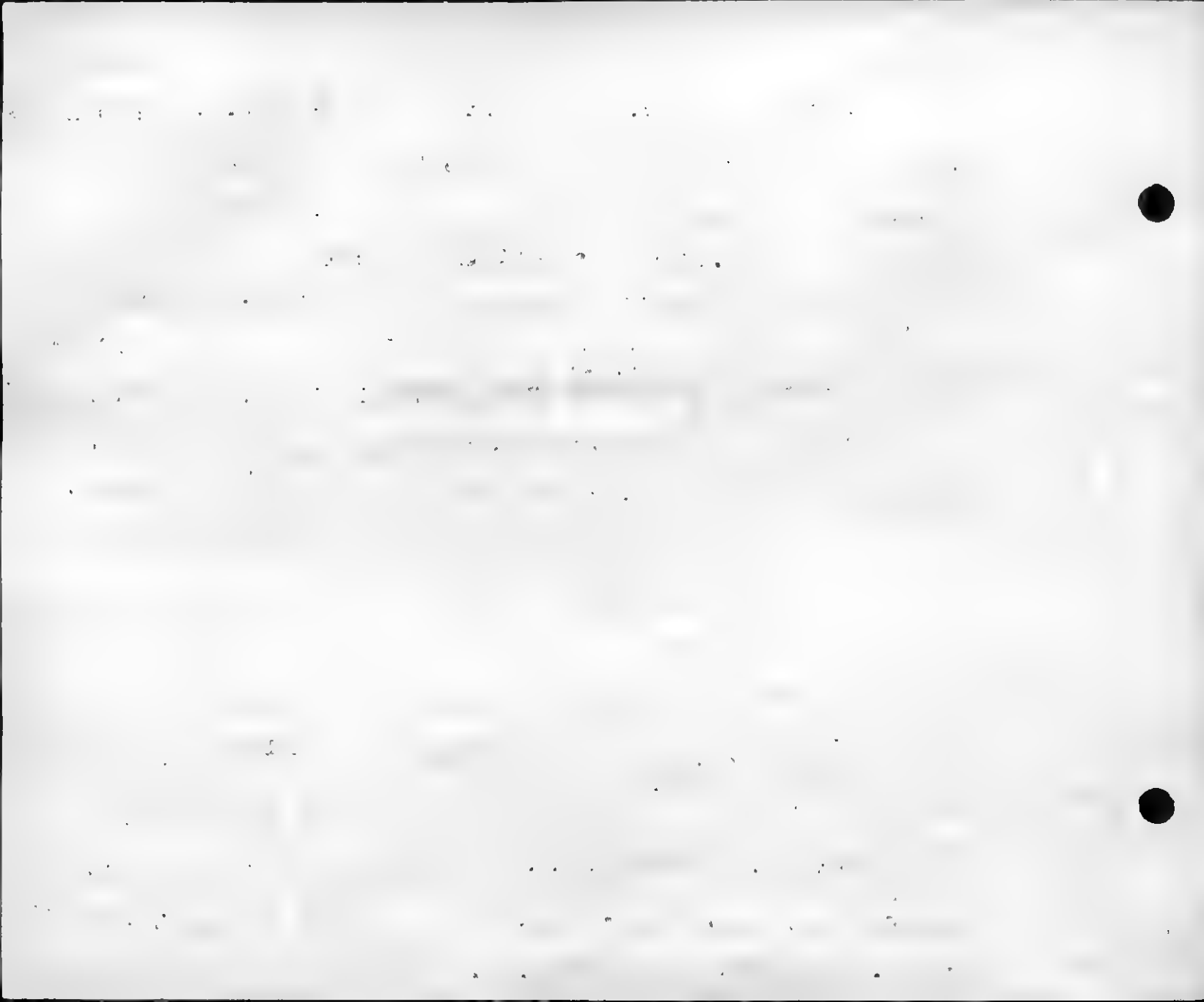
MD249

MD236

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | | | | | |
|--|--|--|--|--|--|--|---|---|---|-----------------------|---|--|
| 1 DECEASED-NAME (Type or print) | | First
JOHN | | Middle
E. | | Last
LANE | | 2a. DATE OF DEATH
Month FEBRUARY Day 10 Year 1968 | | | 2b. HOUR
12:15 AM | |
| 3 SEX
MALE | | 4. RACE
NEGRO | | 5 DATE OF BIRTH
MAY 3, 1913 | | | 6 AGE (In years last birthday)
54 YRS | | F UNDER 1 YEAR
MONTHS 54 DAYS 54 | | IF UNDER 24 HRS
HOURS 54 MIN. 54 | |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | B MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH
BALTIMORE Md | | | | | | |
| 10 CITY OR TOWN OF DEATH
FORT HOWARD | | 11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)
VETERANS ADMINISTRATION HOSPITAL | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
LABORER | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution, Res. before admission) STATE
MARYLAND | | 13b. COUNTY
SOMERSET | | 13c. CITY OR TOWN
CRISFIELD | | 3d. INSIDE CITY L.M.T.?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
139 1/2 S. 4th Street | | | | |
| 14. FATHER'S NAME First
JOHN | | Middle
E | | Last
LANDON | | 15 MOTHER'S MAIDEN NAME First
DORA | | Middle
H | | Last
MORGAN | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) YES (If yes give war or dates of service)
WW II | | 16b. SOCIAL SECURITY NO
216 07 1754 | | 17 INFORMANT Address
CLINICAL RECORDS, VA HOSP. FORT HOWARD, MD | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA TERMINAL
DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF LUNGS
DUE TO, OR AS A CONSEQUENCE OF (c) UNKNOWN | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DAYS | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, FARM, STREET, FACTORY)
OFFICE BUILDING, ETC. | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | | |
| 22a. I certify that 1 (this hospital) attended the deceased from 11/1/67 , 19____, to 2/10/68 , 19____, that 1 (we) last saw the deceased alive on 2/10/68 , 19____, and that in MD (our) opinion death occurred on the date and hour and from the causes stated above 1 (we) (did) not view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Madhav D. Barhanpurkar</i> | | 22c. DATE SIGNED
2/11/68 | | 22d. PHYSICIAN'S NAME (Type)
MADHAV D. BARHANPURKAR, M.D. | | | | | | | | |
| 22e. ADDRESS
VA HOSPITAL, FORT HOWARD, MARYLAND | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
2/14/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Asbury Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Somerset County, Maryland | | | | | | |
| 24. FUNERAL DIRECTOR
Arthur E. Ward Funeral Home, Crisfield, Md. | | 25a. REC'D BY REGISTRAR
FEB 14 1968 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12249

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1235

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME
(Type or) Lillian Maude | | First Last League | | 2a. DATE OF DEATH
Month Feb. Day 29 Year 68 | | 2b. HOUR
8:30 <small>AM</small> | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
APRIL 19, 1880 | | 6. AGE (In years lost birthday)
87 YRS | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore | |
| 10. CITY OR TOWN OF DEATH
Garrison | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Foxleigh Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUA. RESIDENCE (Where deceased lived, if institut on- Residence before admission) STATE
Maryland | | 13b. COUNTY
Balto | | 13c. CITY OR TOWN
Balto | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME First Middle Last
Henry Hildt | | 15. MOTHER'S MAIDEN NAME First Middle Last
Hannah E. Hutchins | | 13e. STREET AND NUMBER
3627 Marriotts Lane 21207 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) No | | 16b. SOCIAL SECURITY NO.
215-54-1831 | | 17. INFORMANT Address
Mr. Howard Hughes 3627 Marriotts Lane 21207 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial insufficiency
+ 13 X DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) A. febrile diseases
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
days.
unknown | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY)
OFFICE BUILDING, ETC | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10-12 , 19 67 , to 2-29 , 19 68 , that <input checked="" type="checkbox"/> (I) (we) lost
saw the deceased alive on 2-28 , 19 68 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the
causes stated above, <input checked="" type="checkbox"/> (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
David J. Miller | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
2/29/68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
David J. Miller | | 22e. ADDRESS
Leason Rd. Owings Mills, Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3/2/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Durid Ridge Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Pikesville Balto Co Md | |
| 24. FUNERAL DIRECTOR
Erving Byers 8728 | | ADDRESS
Liberty of Nandall St | | 25a. REC'D BY REGISTRAR
DATE MAR 4 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles J. [Signature] | |

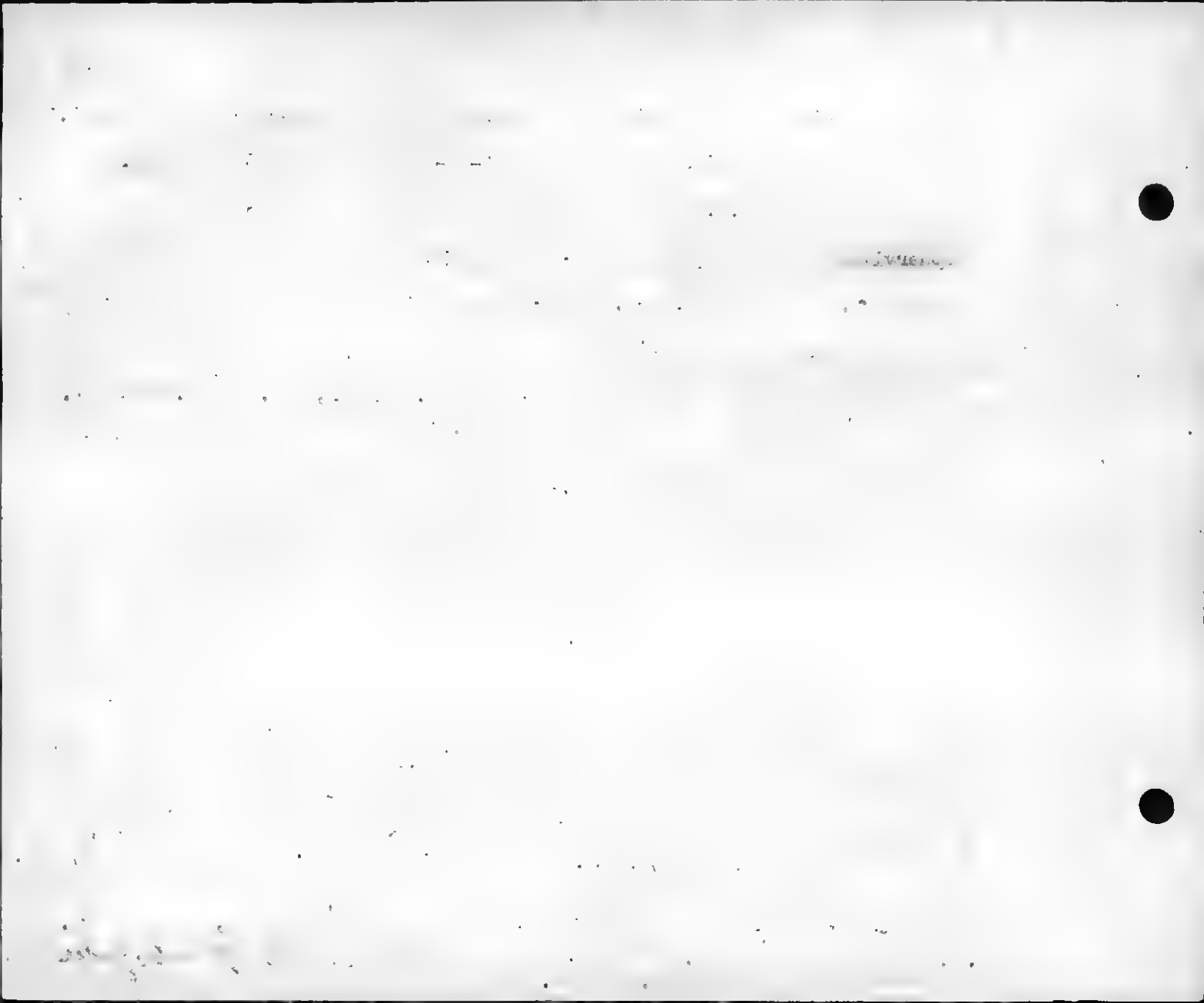
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| Item 13a,b,c, & Film G398 2/28/68 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1 DECEASED NAME (Type or print) | | | First Middle Last | | | 2a DATE OF DEATH | | | 2b HOUR | | |
| Marion Paige Leake | | | | | | Month Day Year | | | February 15 1968 | | |
| 3 SEX | | | 4 RACE | | | 5. DATE OF BIRTH | | | 6 AGE (In years last birthday) | | |
| Female | | | White | | | 4-29-1882 | | | 85 YRS. | | |
| 7a BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | |
| New Jersey | | | U.S.A. | | | | | | Baltimore Md | | |
| 10 CITY OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| Lutherville | | | College Manor Nursing Home | | | House Wife | | | Own Home | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE | | | 13b. COUNTY | | | 13c CITY OR TOWN | | | 13d INSIDE CITY, J.M.T.S? | | |
| New York Md. | | | Balto. | | | Lutherville | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 13e STREET AND NUMBER | | | | | |
| First Middle Last | | | First Middle Last | | | 200 E. 66th Street | | | | | |
| Eugene Paige | | | Ada Bancroft | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17 INFORMANT | | | Address | | |
| No | | | | | | Eugene W. Leake, Jr. Garrison, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive CVA | | | | | | | | | | 78 hrs. | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| None | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| | | | | | | | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from September, 19 67, to 2/15, 19 68, that (I) (we) last saw the deceased alive on 2/15, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE William F. Fritz M.D. | | | | | | | | | | | |
| 22c. DATE SIGNED 2/16/68 | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) WILLIAM F. FRITZ, M.D. | | | | | | | | | | | |
| 22e ADDRESS 2 W. University Pkwy. Balto. 18, Md. | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | | 23b DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d LOCATION (City or Town) (County) (State) | | |
| Cremation | | | 2/15/68 | | | Greenmount | | | Baltimore, Md. | | |
| 24 FUNERAL DIRECTOR | | | ADDRESS | | | 25a REC'D BY REGISTRAR | | | 25b REGISTRAR'S SIGNATURE | | |
| H.W. Jenkins & Sons Co. | | | 4905 York Road Balto. 12, Md. | | | DATE Feb 15 1968 | | | Charles Judge | | |



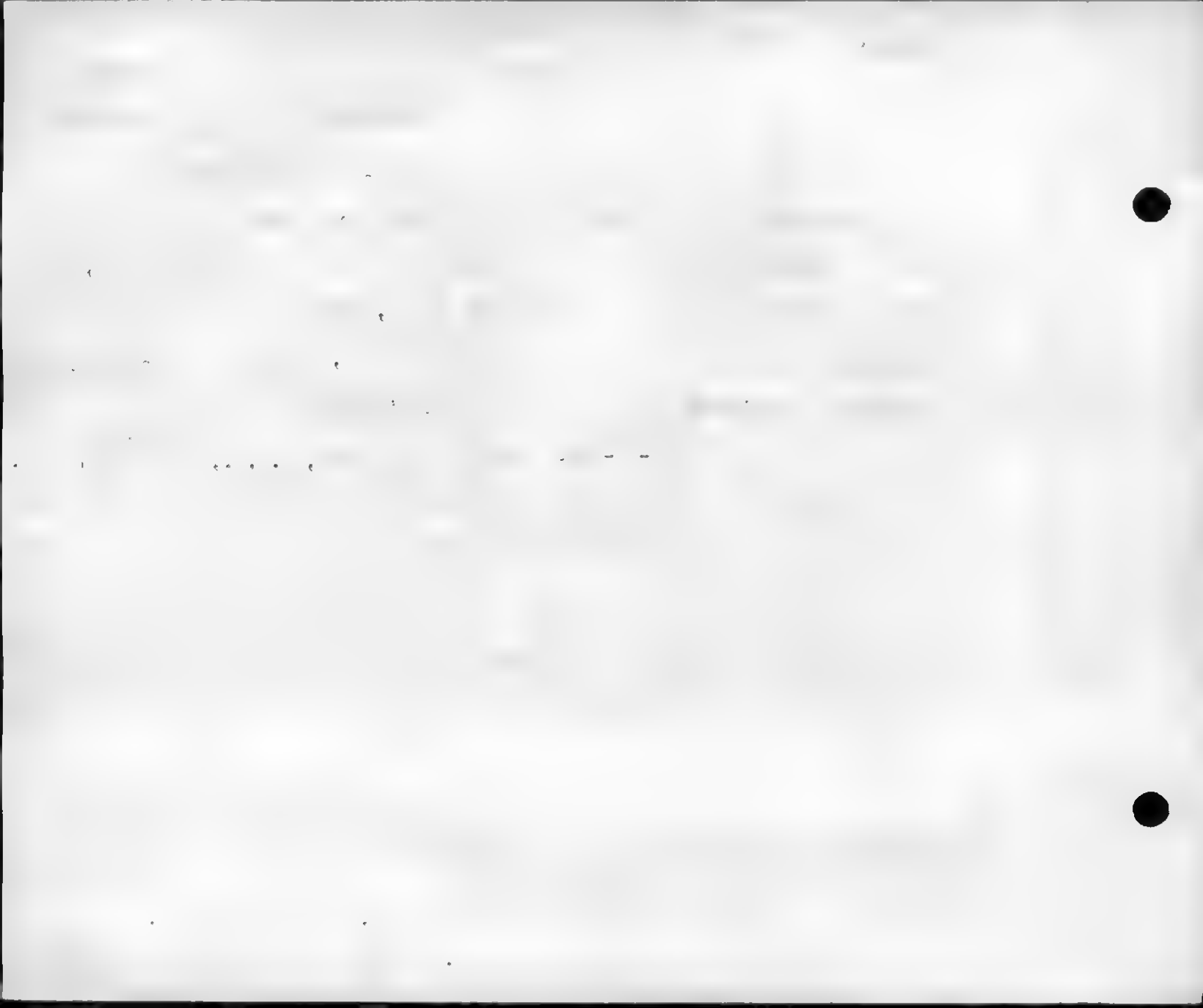
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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| | | | |
|---|---|---|---|
| 1 PLACE OF DEATH
a COUNTY Baltimore
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore
c LENGTH OF STAY IN b
1 1/2 years
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Mercy Villa Nursing Home | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE Maryland b COUNTY Baltimore
c CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town)
Baltimore (Cockeysville)
d STREET ADDRESS
33 Cedar Knoll Road
e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print)
Elizabeth Rolle
First Middle Last
Lehner | | 4 DATE OF DEATH
Month Day Year
February 18, 1968 | |
| 5 SEX
Female | 6 COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH
August 12, 1893 |
| 9 AGE (in years lost birthday)
74 yrs | | 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | 10b KIND OF BUSINESS OR INDUSTRY |
| 11 BIRTHPLACE (County & State, or foreign country)
Baltimore, Maryland | | 12 CITIZEN OF WHAT COUNTRY?
United States | |
| 13. FATHER'S NAME
Christopher Cunningham | | 14. MOTHER'S MAIDEN NAME
Louise Parr | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO
219-30-6552 | |
| 17. INFORMANT
Sister M. Carlotta, R.S.M., 6400 Bellona Ave. | | Address Mercy Villa | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Cardio-Vascular Disease
2504 DUE TO (b) Diabetes Mellitus
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0X | | INTERVAL BETWEEN ONSET AND DEATH
2 years
10 years | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f (City or town) (County) (State) |
| 21 I certify that (I) (the hospital) attended the deceased from October 2, 1967 to Feb. 17, 1968 , that (I) (we) last saw the deceased alive on 2-17 1968, and that death occurred at 8 P M, from causes and on the date stated above. | | | |
| 22a SIGNATURE
Philip H. Lynn M.D. | | 22b DATE SIGNED
2-19-68 | |
| 22c PHYSICIAN'S NAME (Type) | | 22d ADDRESS | |
| 23a BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b DATE THEREOF
2/21/1968 | 23c NAME OF CEMETERY OR CREMATORY
Holy Redeemer Cent. | 23d LOCATION (City or Town) (County) (State)
Baltimore, Md. |
| 24 FUNERAL DIRECTOR
Mitchell- Wiedefeld Home | | 25a REC'D BY REGISTRAR
DATE FEB 21 1968 | |
| ADDRESS
6500 York Rd. | | 25b REGISTRAR'S SIGNATURE
Charles J. [Signature] | |



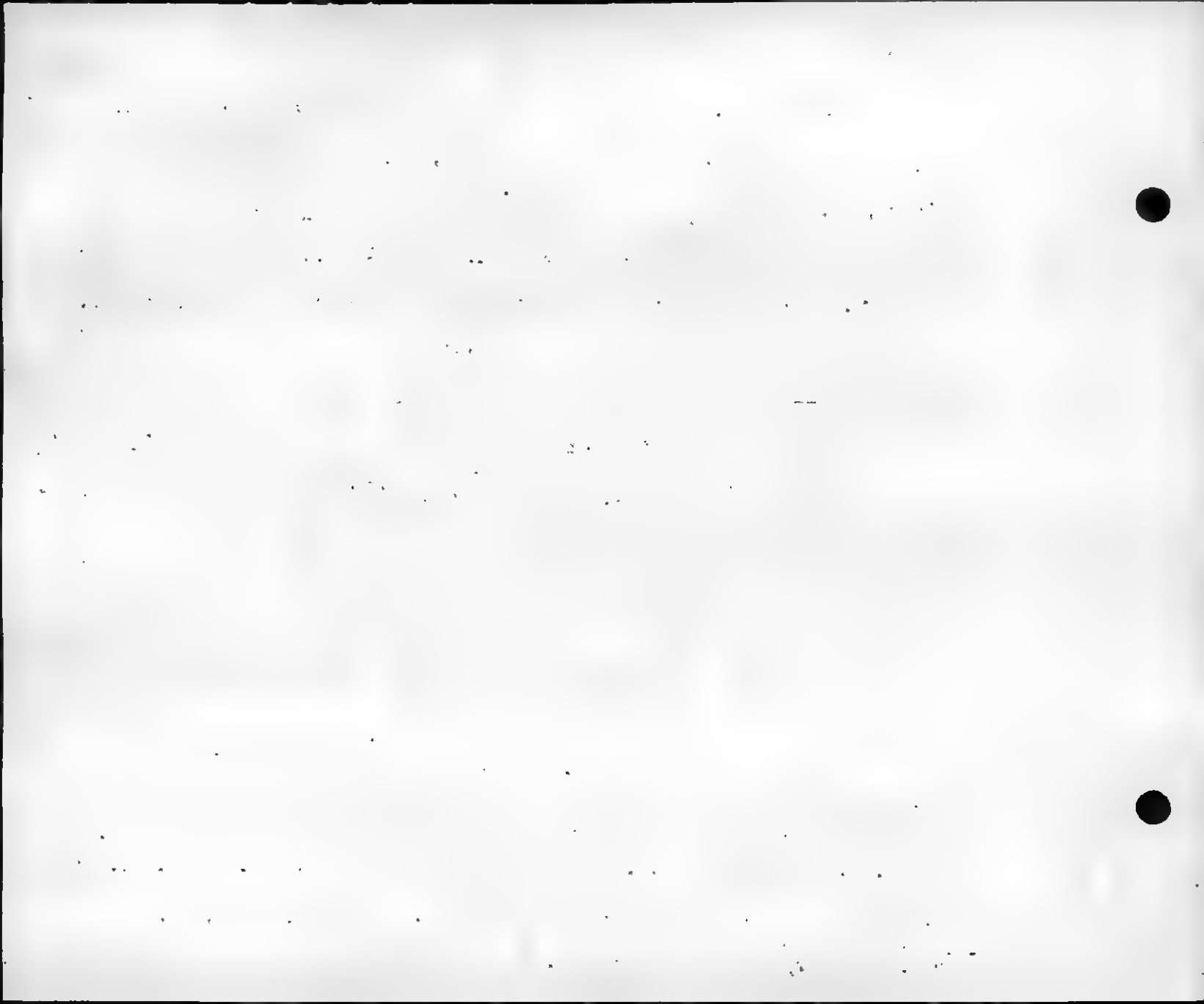
TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 12 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

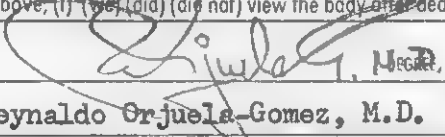
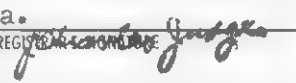
CERTIFICATE OF DEATH

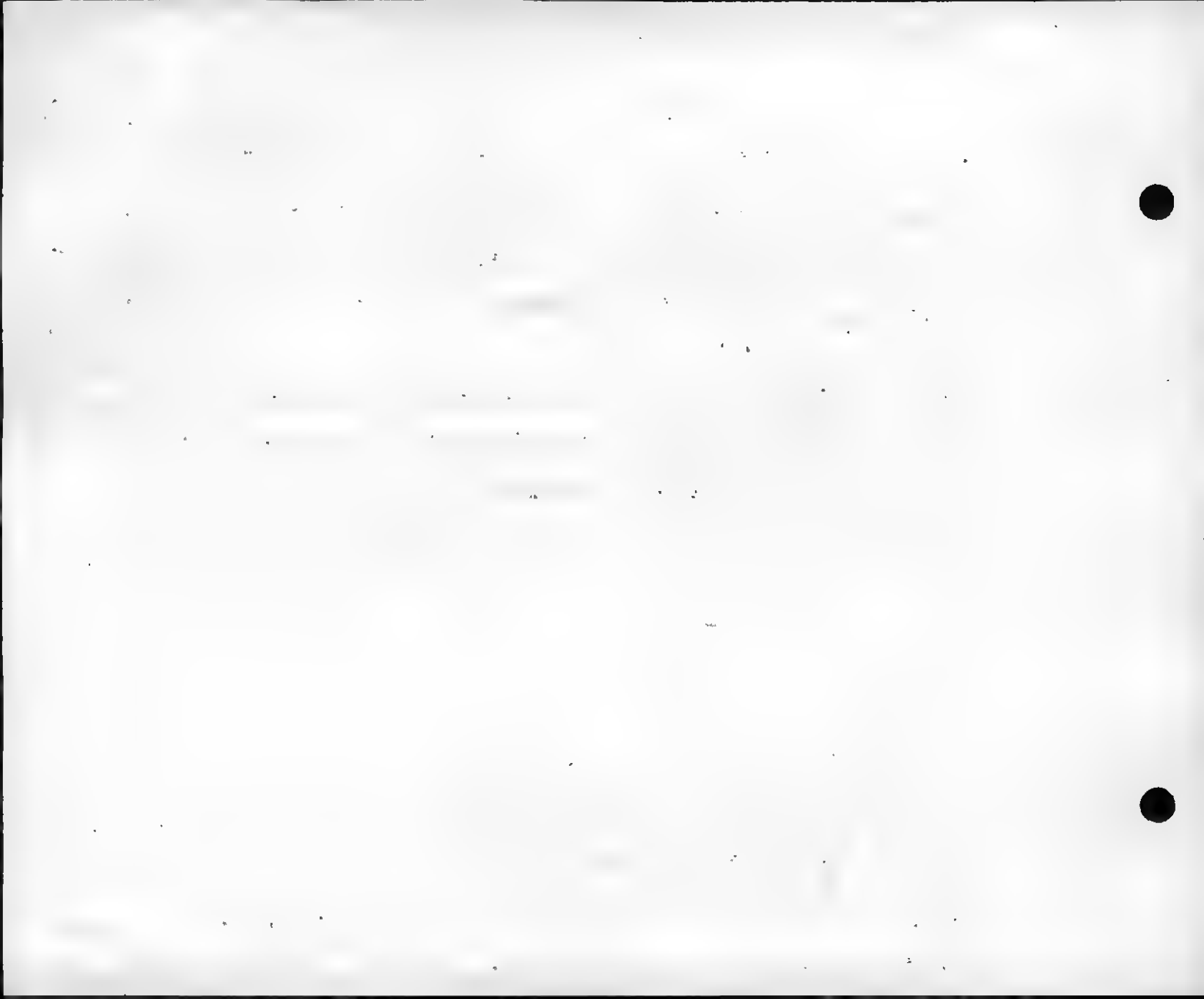
| | | | | | | | | |
|--|--|---|---|---|--|---|---|--|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH
February 19 Day 1968 | | 2b. HOUR
/ M | |
| FLORENCE S. LESCALLETTE | | | | | | | | |
| 3 SEX
Female | 4 RACE
White | 5 DATE OF BIRTH
May 3, 1905 | | | 6 AGE (In years
last birthday)
62 YRS. | 7. UNDER 1 YEAR
MONTHS DAYS | | 8. UNDER 24 HRS
HOURS MIN |
| 7a. BIRTHPLACE (State or foreign
country)
Baltimore, Md. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Baltimore | | Md | |
| 10 CITY OR TOWN OF DEATH
Essex (21) | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp to
give street address)
1612 Rickenbacker Rd. | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even retired)
Housewife | | 12b. KIND OF BUSINESS OR
INDUSTRY
Home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before
admission) STATE
Md. | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Essex (21) | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER
1612 Rickenbacker Rd. | | | | |
| 14. FATHER'S NAME
First Middle Last
Samuel Moore | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Alvina | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) (If yes give year or dates of service)
No -- | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT
Robert Lescallette | | Address
Same | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>
4109 DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Arteriosclerotic Cardiovascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>2 yrs</u>
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>Sudden</u> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1, 1967, to Feb 19, 1968, that (I) (we) last
saw the deceased alive on Feb 18, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
M. Baumgradner | | | | | DEGREE
ATTENDING
PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
2/20/68 | |
| 22d. PHYSICIAN'S
NAME (Type) M. Baumgradner, M.D. | | | | | 22e. ADDRESS
8552 Philadelphia Rd. Balto. Md. 21237 | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE
2/23/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Holly Hill Memorial Gardens | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | | |
| 24. FUNERAL DIRECTOR
James E. Bruzdinski 1407 Eastern Ave. | | | | | 25a. REC'D BY REGISTRAR
DATE FEB 27 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Jones | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|--|--|--|---|--|-------------------------------|---------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
George | | | Middle
Maxwell | | | Last
LESTER | | | 2a. DATE OF DEATH
Month Day Year
February 20, 1968 | | | 2b. HOUR
9:15AM | |
| 3 SEX
Male | | | 4. RACE
White | | | 5. DATE OF BIRTH
May 6, 1920 | | | 6. AGE (In years last birthday)
47 YRS. | | | 7. UNDER 1 YEAR
MONTHS DAYS | | 8. UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
Virginia | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Baltimore, | | | Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)
ST. JOSEPH HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Steel worker | | | 12b. KIND OF BUSINESS OR INDUSTRY
Beth Steel | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Baltimore | | | 13c. CITY OR TOWN
Essex | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER
129 Riverside Rd. | | | | |
| 14. FATHER'S NAME
First Middle Last
George Lester | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Jean Frye | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) (If yes give war or dates of service)
Yes WWII | | | 16b. SOCIAL SECURITY NO
244 16 8853 | | | 17. INFORMANT
M. Irene Lester | | | Address
Same | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1 DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Massive recurrent myocardial infarction
4109
DUE TO, OR AS A CONSEQUENCE OF
(b) Coronary thrombosis
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.) | | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | | | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from 2/17/ 19 68 , to 2/20/ 19 68 , that (I) (we) last saw the deceased alive on 2/20/ 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
 | | | 22c. DATE SIGNED
February 20, 1968 | | | 22d. PHYSICIAN'S NAME (Type)
Reynaldo Orjuela-Gomez, M.D. | | | 22e. ADDRESS
7620 York Rd., Towson, Md. 21204 | | | | | | | |
| 23a. BURIAL, CREMATION, or other disposal (Specify) | | | 23b. DATE
2/23/68 | | | 23c. NAME OF CEMETERY OR CREMATORY
Elk Run Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Elkton, Va. | | | | | | | |
| 24. FUNERAL DIRECTOR
Bruzdzinski Funeral Home 1407 Eastern Ave. | | | ADDRESS | | | 25a. REC'D BY REGISTRAR
FEB 27 1968 | | | 25b. REGISTERED
 | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2. should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | | |
|---|-----------------------------|---|--------|---|--|---|---|----------------------------------|--|
| 1 DECEASED NAME
(Type or print) | | First | Middle | Last | 2a DATE OF DEATH | Month | Day | Year | 2b HOUR |
| BERTHA | | | | LEVI | FEB | | 13 | 1968 | 10 A M |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | | | 6 AGE (In years last birthday) | | 7 IF UNDER 1 YEAR | | 8 IF UNDER 24 HRS |
| F | WHITE | 12-28-1888 | | | 79 YRS. | | MONTHS DAYS | | HOURS MIN |
| 7a BIRTHPLACE (State or foreign country) | 7b CITIZEN OF WHAT COUNTRY? | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| GERMANY | USA | | | BALTIMORE Md | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b KIND OF BUSINESS OR INDUSTRY | |
| | | 3111 SMITH AVE | | | CLEAN | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER | |
| MD | | BALTO | | | | | | 3111 SMITH AVE | |
| 14 FATHER'S NAME | | First | Middle | Last | 15 MOTHER'S MAIDEN NAME | | First | Middle | Last |
| Solomon | | | | | NANNI | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b SOCIAL SECURITY NO | | 17 INFORMANT | | | Address | | |
| NO | | 216-34-4149 | | RUTH GOLDSCHMIDT | | | 3111 SMITH AVE | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Struck Adam (Hendrick) | | | | | | | | | 3 yr |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis C.D.D. | | | | | | | | | 70 yr |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| Lung cancer | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | Pneumonia 2/1/68 | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC) | | 21f. LOCATION | | Street or R.F.D. No | | City or Town | County |
| | | | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 1937, 19 to 2/13, 1968, that (I) (we) last saw the deceased alive on 2/13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (aid) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE | | | | | | | | 22c DATE SIGNED | |
| Joseph B Gross | | | | | | | | | |
| 22d PHYSICIAN'S NAME (Type) | | | | | | | | 22e ADDRESS | |
| Joseph B Gross | | | | | | | | 6941 Park Heights Baltimore Md | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) | | (County) | (State) |
| Burial | | 2/14/1968 | | Chesapeake Chapel | | Rosedale | | | Md |
| 24 FUNERAL DIRECTOR | | | | ADDRESS | | 25a REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | |
| Sybil S. Lewis & Son, Inc | | | | Garrison | | DATE FEB 15 1968 | | Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

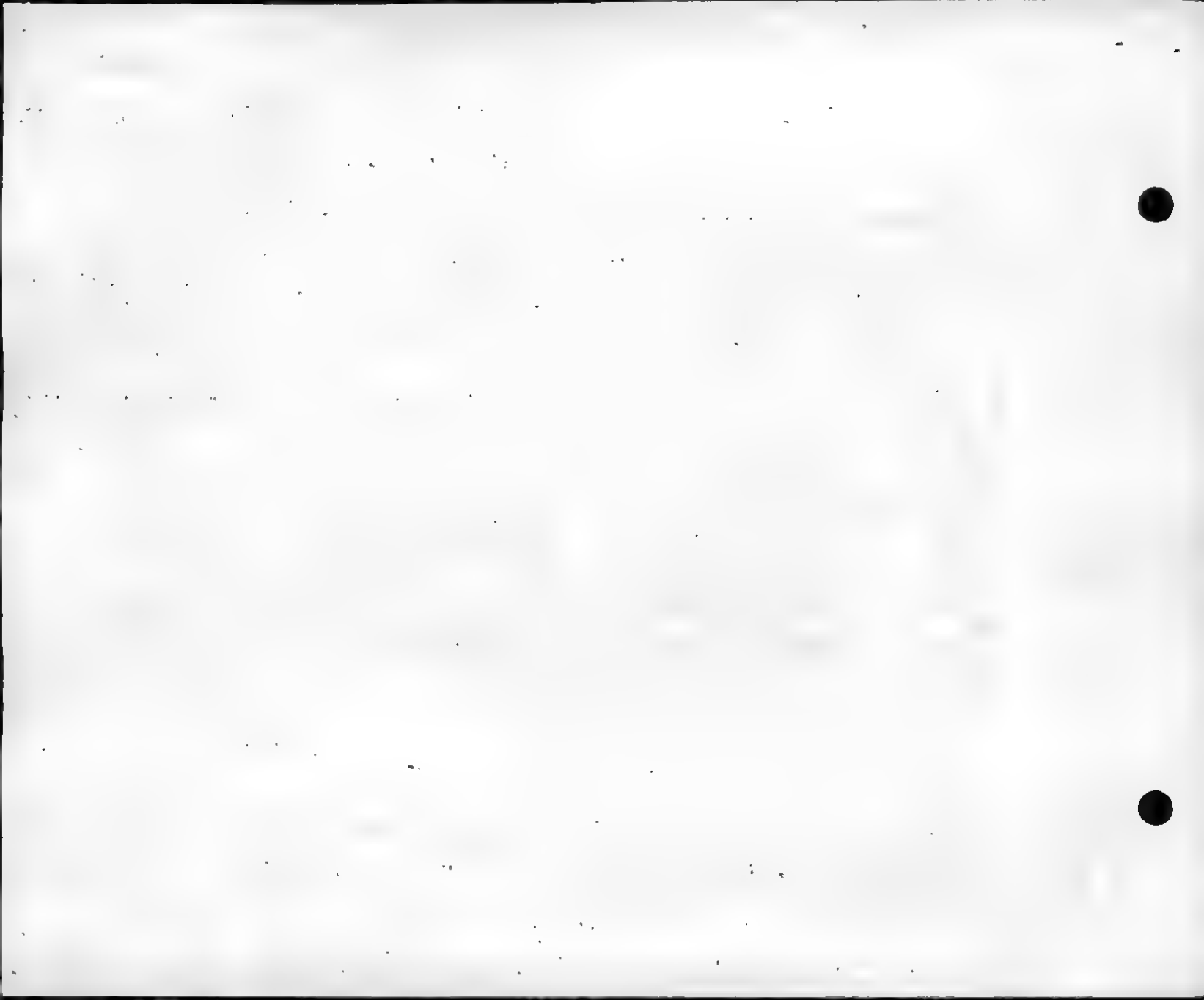
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15 (4)
30M REV. 1/58

02255
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02243

| | | | | | |
|---|--|---|--|---|---|
| 1. DECEASED-NAME
(Type or print) First Middle Last
GERTRUDE COPLAN LEVIN | | | 2a. DATE OF DEATH
Month Day Year
FEBRUARY 15, 1968 | | 2b. HOUR
7:30 P.M. |
| 3 SEX
FEMALE | 4 RACE
WHITE | 5. DATE OF BIRTH
AUGUST 14, 1894 | | 6 AGE (In years last birthday)
73 YRS | 7. UNDER 1 YEAR
MONTHS DAYS HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)
BALTIMORE, MD | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE Md. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
PROFESSIONAL HOUSE | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
HOUSEWIFE | 12b. KIND OF BUSINESS OR INDUSTRY
AT HOME |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
3600 LABYRINTH RD. |
| 14. FATHER'S NAME First Middle Last
LOUIS ELI COPLAN | | | 15. MOTHER'S MAIDEN NAME First Middle Last
JENNIE ZELDA | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16b. SOCIAL SECURITY NO | 17. INFORMANT Address
MR. ROBERT C. LEVIN, 8205 MARCIE DR. #21208 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>
4310
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) <u>Hypertension</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Extrinsic infection</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:
3 days
1941
1962 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or RFD No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY 1941, to FEB. 15, 1968, that (I) (we) last saw the deceased alive on FEB. 15, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
DR. SAMUEL WHITEHOUSE | | | | 22c. DATE SIGNED
2/16/68 | |
| 22d. PHYSICIAN'S NAME (Type)
DR. SAMUEL WHITEHOUSE | | 22e. ADDRESS
3900 N. CHARLES STREET | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
2-16-68 | 23c. NAME OF CEMETERY OR CREMATORY
Mikro Kodesh Beth Israel | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND |
| 24. FUNERAL DIRECTOR
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | | 25a. REC'D BY REGISTRAR
DATE FEB 20 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles J. Jones |



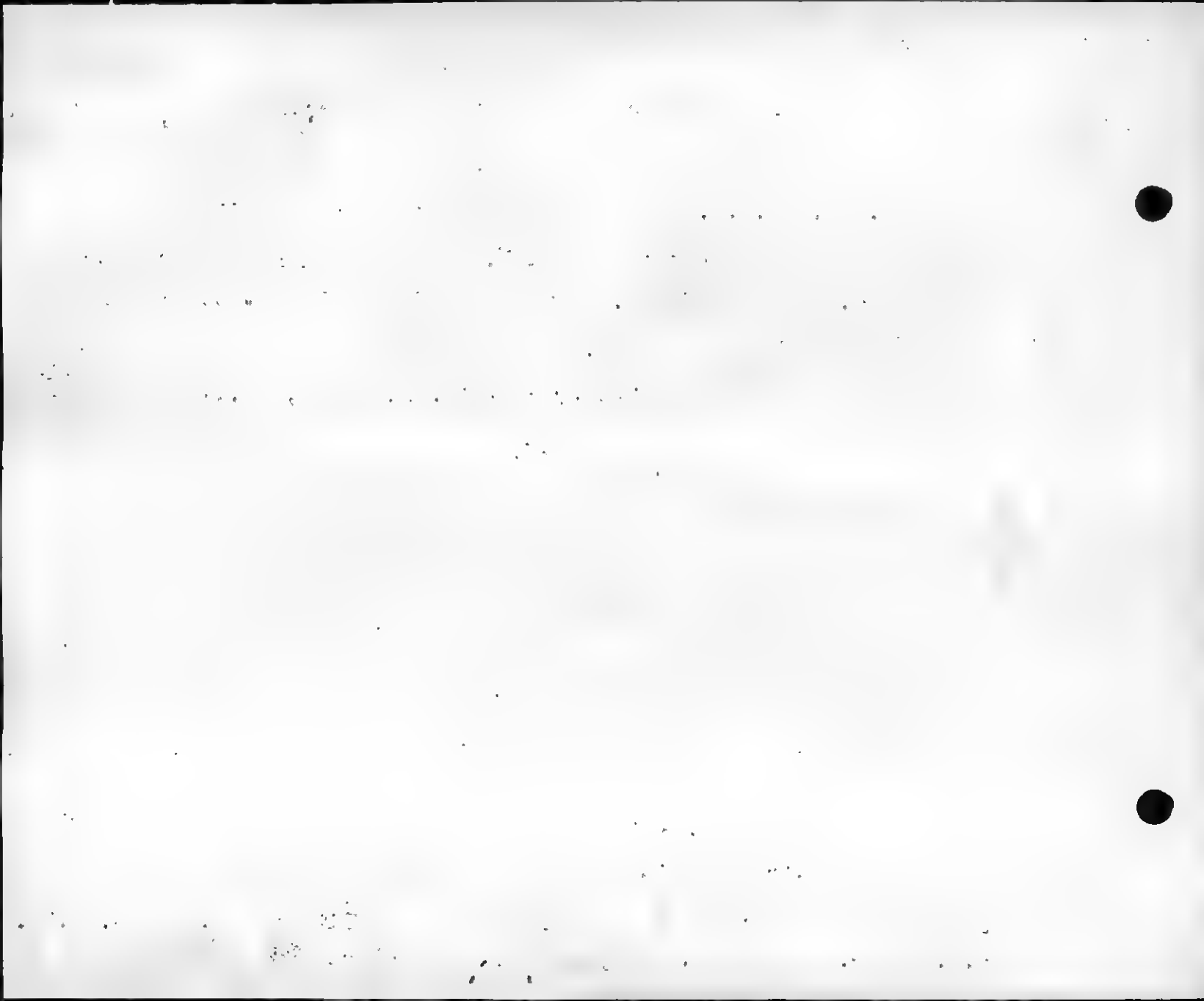
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-----------------------------|--|
| 1 DECEASED NAME
(Type or print) | | | First
Alice | | | Middle
Black | | | Last
Lewis | | | 2a DATE OF DEATH
Month February Day 18 Year 1968 | | | 2b HOUR
5:35 P.M. | |
| 3 SEX
F | | | 4 RACE
W | | | 5 DATE OF BIRTH
4/16/1907 | | | 6 AGE (In years last birthday)
60 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN | | |
| 7a BIRTHPLACE (State or foreign country)
Balto., Md. | | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | 9 COUNTY OF DEATH
Baltimore Md | | | | | | | |
| 10 CITY OR TOWN OF DEATH
Towson | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Hampton House Apt. | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Homemaker | | | 12b KIND OF BUSINESS OR INDUSTRY
Own Home | | | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | 13b. COUNTY
Balto. | | | 13c CITY OR TOWN
Towson | | | 3d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e STREET AND NUMBER
316 Hampton House | | | | |
| 14. FATHER'S NAME First
Duncan | | | Middle
Black | | | Last
Lewis | | | 15. MOTHER'S MAIDEN NAME First
Anna | | | Middle
Ridgely | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No | | | 16b SOCIAL SECURITY NO
220-44-1489 | | | 17 INFORMANT
Fielding H. Lewis, Jr. | | | Address
Drive | | | 17b STREET AND NUMBER
7303 Yorktown | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Leukemia
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b TIME OF INJURY
HOUR A.M. 19 Month Feb Day 18 Year 1968 | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | |
| 21d INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f LOCATION
Street or R.F.D. No. Sec 1 City or Town Towson County Baltimore State Md. | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 1, 1967 to Feb 18, 1968 , that (I) (we) last saw the deceased alive on Feb 18, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | | | | | | | | | |
| 22b SIGNATURE
Laurence C. Post M.D. | | | 22c. DATE SIGNED
2/19/68 | | | 22d. PHYSICIAN'S NAME (Type)
Dr. Laurence C. Post | | | 22e. ADDRESS
6805 York Road | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
2/20/68 | | | 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge | | | 23d. LOCATION (City or Town) (County) (State)
Pikesville, Balto. Co. Md. | | | | | | | |
| 24. FUNERAL DIRECTOR
H.W. Jenkins & Sons Co. | | | ADDRESS
4905 York Rd. Balto., Md. | | | 25a REC'D BY REGISTRAR
DATE FEB 19 1968 | | | 25b REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | |

MEDICAL CERTIFICATION

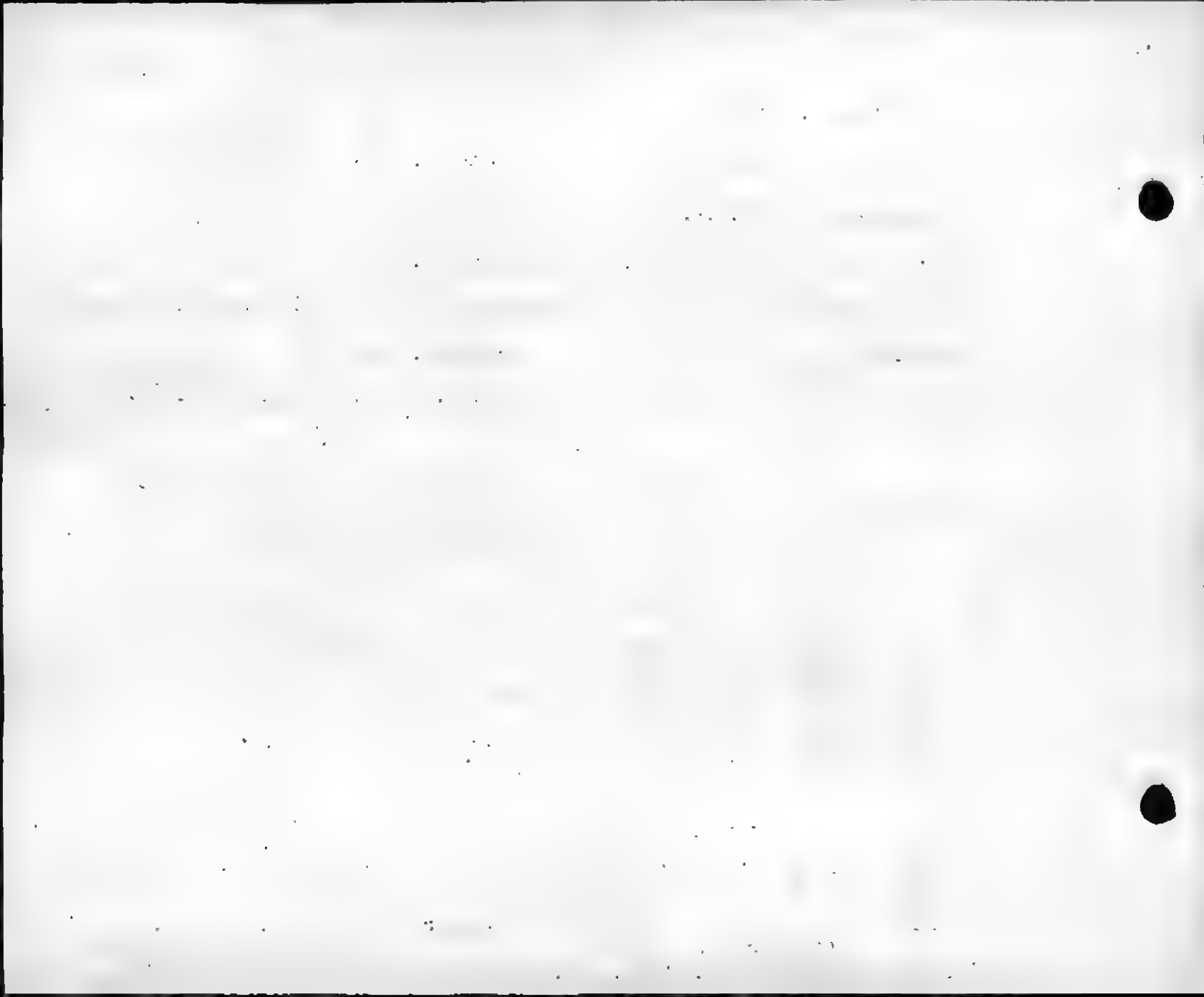


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|---|---|--|--|--|
| 2225 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | Item #23b F | | 2245 | |
| 1 DECEASED NAME (Type or print) Lola E. Lewis | | | 2a DATE OF DEATH
Month 2 Day 6 Year 68 | | | 2b HOUR 6 A M | |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH July 3, 1898 | | 6 AGE (In years last birthday) 69 YRS | |
| 7a BIRTHPLACE (State or foreign country) Maryland | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH BALTIMORE Md | |
| 10. CITY OR TOWN OF DEATH Balto. | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5901 Edmondson Ave. | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland | | 13b. COUNTY Baltimore | | 13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER 5901 Edmondson Avenue | |
| 14 FATHER'S NAME First Adekert Hooper Middle Last | | | 15. MOTHER'S MAIDEN NAME First Martha V. Parks Middle Last | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown no (If yes give war or dates of service) | | 16b SOCIAL SECURITY NO. | | 17. INFORMANT 5950 Wilson Boulevard
Martha L. Glass, Arlington, Va. 22205 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma metastasis
114X DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 months | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
1102 | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner) | | 21b TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July , 19 67 , to Feb 6 , 19 68 , that (I) (we) last saw the deceased alive on Feb 6 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE L.A. Lally M.D. DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c DATE SIGNED February 7 1968 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) L.A. LALLY M.D. | | 22e ADDRESS ROLLING Rd - FREDERICK AVE | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b DATE 2/8/68 | | 23c NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | 23d. LOCATION (City or Town) (County) (State) Balto. Md. | |
| 24. FUNERAL DIRECTOR 4101 Edmondson Avenue | | 25a REC'D BY REGISTRAR FILED 8 1968 | | 25b REGISTRAR'S SIGNATURE Charles Judge | | | |
| Witzke Funeral Directors, Balto., Md. 21229 | | | | | | | |



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1-2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | |
|--|----------------------|---|---|--|--|--|--|--|
| 1 DECEASED NAME
(Type or Print) MARTHA EANE LILLY | | | 2a DATE KNOWN OF DEATH
Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year <input checked="" type="checkbox"/> Feb 26 1968 | | | 2b HOUR
5A M | | |
| 3 SEX
Female | 4 RACE
Can | 5 DATE OF BIRTH
Mar 20, 1896 | 6 AGE (in years last birthday)
81 YRS | 7 UNDER 1 YEAR
MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> | IF UNDER 24 HRS
HOURS <input type="checkbox"/> MIN <input type="checkbox"/> | 2c DATE PRONOUNCED DEAD
Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year <input checked="" type="checkbox"/> Feb 26 1968 | | |
| 7a BIRTHPLACE (State or foreign country)
W. Va. | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore | | |
| 10 CITY OR TOWN OF DEATH
White Hall | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Central Ave | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
None |
| 13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE W. Va. | | | 13b COUNTY
Frederick | | | 13c CITY OR TOWN
Frederick | | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 13e STREET AND NUMBER
— | | | 4 FATHER'S NAME
First John Middle Snuffer Last Snuffer | | | 15 MOTHER'S MAIDEN NAME
First ? Middle ? Last ? | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) | | | 16b SOCIAL SECURITY NO
— | | | 17. INFORMANT
Family | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Hypertensive Heart Disease
403
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost
(b) —
DUE TO, OR AS A CONSEQUENCE OF
(c) — | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
mol | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
1st 3x | | | | | | | | |
| 19a. DATE OF OPERATION
2/29/68 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
19 | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | 21b TIME OF INJURY Month, Day, Year
HOUR A.M. 19
P.M. 19 | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f LOCATION Street or R.F.D. No — City or Town — County — State — | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE
A.M. France | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b DATE SIGNED
2/26/68 | | |
| EXAMINER'S NAME (Type)
A.M. FRANCE | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| | | | ADDRESS (Street, city, town, or county)
PARKTON, BALTO, Md | | | | | |
| 23a BURIAL CREMATION, REMOVAL (Specify)
Burial | | | 23b DATE
2/29/68 | | | 23c NAME OF CEMETERY OR CREMATORY
Calver | | |
| 23d LOCATION (City or Town)
Calver | | | 23e LOCATION (County)
Md | | | 23f LOCATION (State)
Md | | |
| 24 FUNERAL DIRECTOR
Wm Cook, Brooks Towson | | | ADDRESS
4050 York | | | 25a REC'D BY REG STRAR
DATE FEB 29 1968 | | |
| | | | 25b REG STRAR'S SIGNATURE
Charles Judge | | | | | |

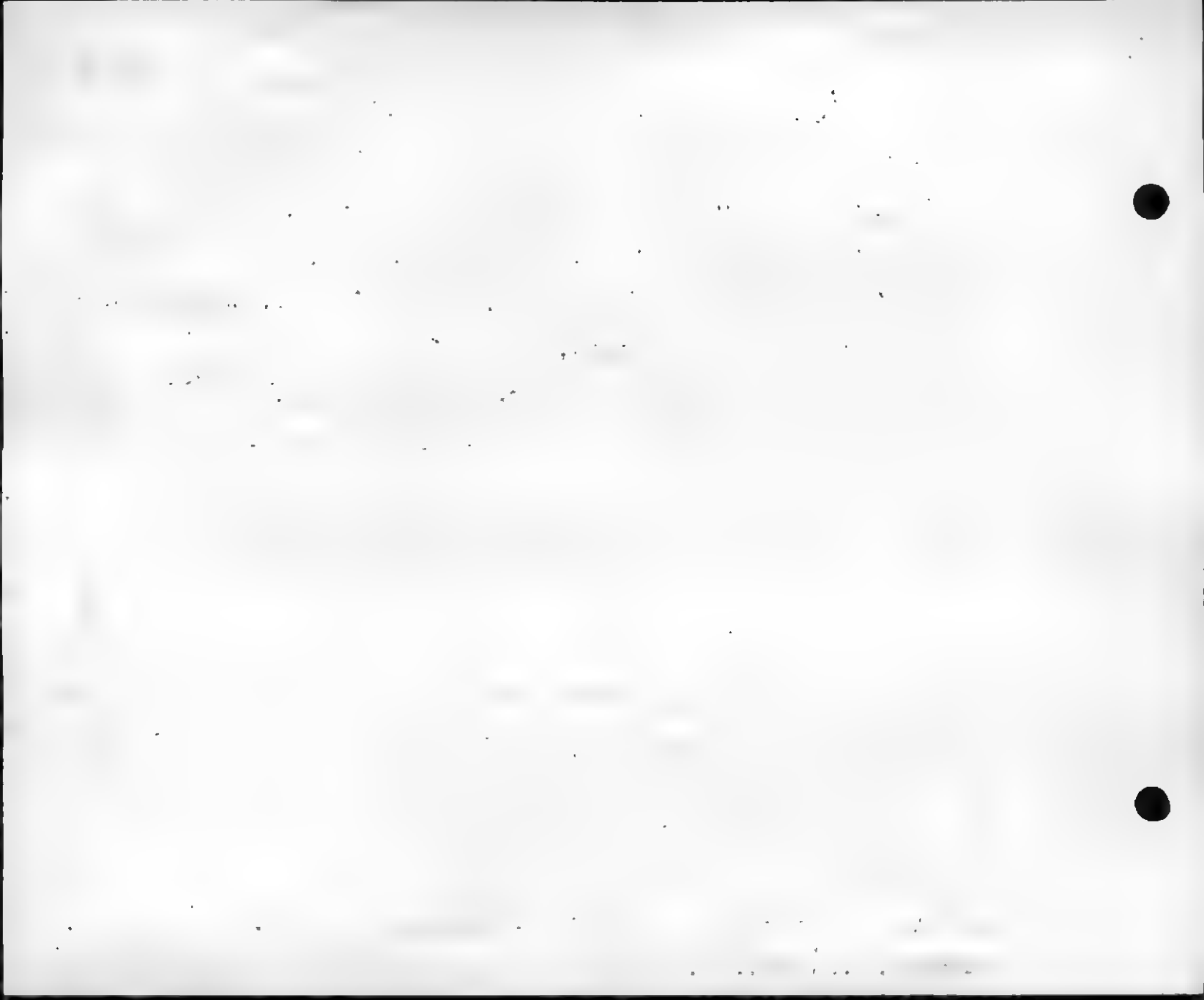
Removed to Calver
Baltimore
W. Va.



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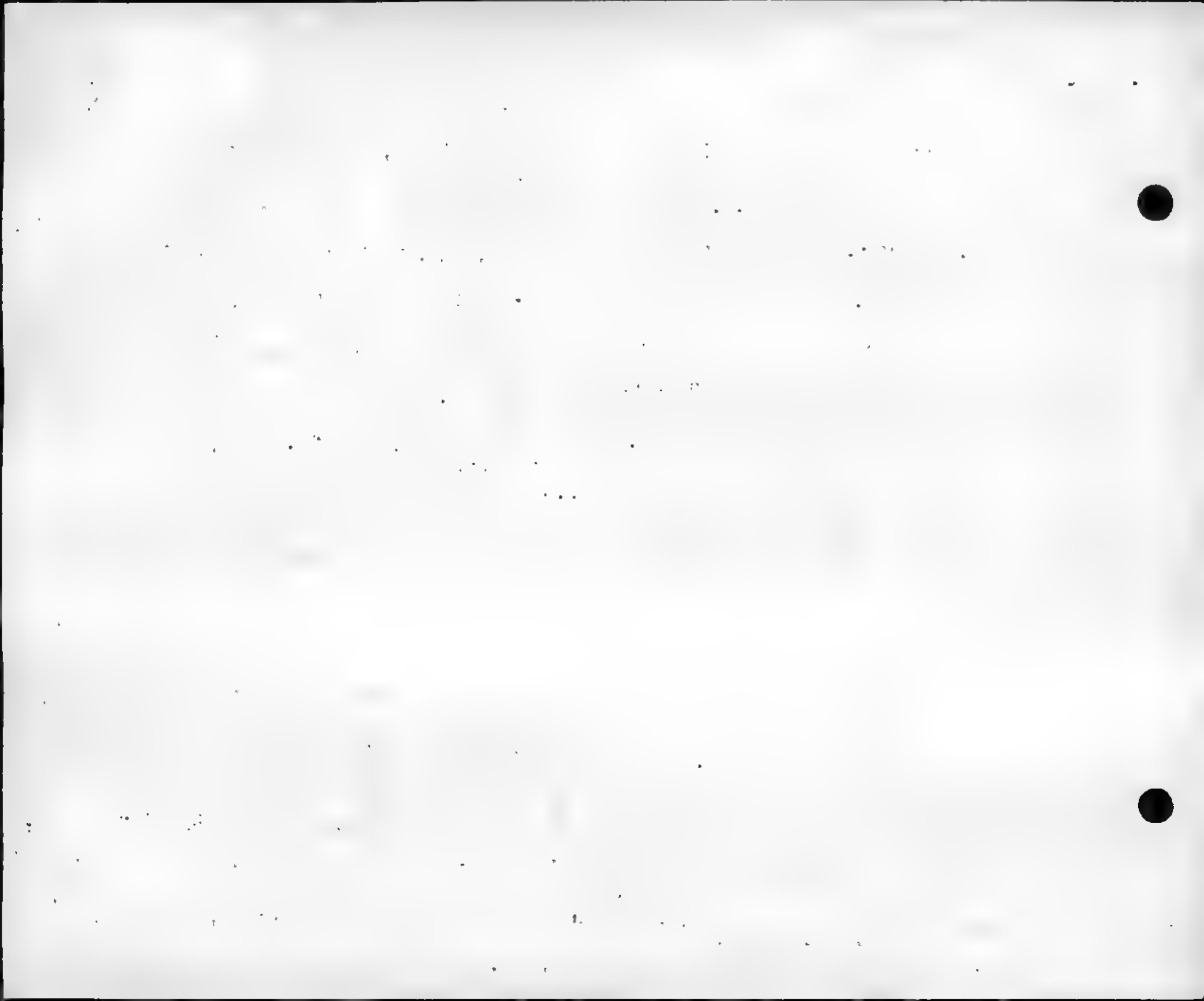
| <div style="text-align: center;"> <p>36253</p> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</p> <p>CERTIFICATE OF DEATH</p> <p style="text-align: right;">02246</p> </div> | | | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|---|--|---|
| 1. DECEASED NAME (Type or print) <u>SUSIE</u> First <u>BOUGHTON</u> Middle <u>LITTLEPAGE</u> Last | | | | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| 3 SEX <u>FEMALE</u> | | | 4 RACE <u>CAUCASIAN</u> | | | 5 DATE OF BIRTH <u>OCT 25, 1888</u> | | | 6 AGE (In years last birthday) <u>85</u> YRS. | | 7. UNDER 1 YEAR
MONTHS DAYS |
| 7a BIRTHPLACE (State or foreign country) <u>VIRGINIA</u> | | | 7b CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH <u>Balto.</u> Md. | | |
| 10. CITY OR TOWN OF DEATH <u>CATONSVILLE, MD</u> | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SHAWNEE-LA N.H.</u> | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>HOUSEWIFE</u> | | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| 13a USUAL RESIDENCE (Where deceased lived, if admission) STATE <u>MD.</u> | | | 13b COUNTY <u>BALTO.</u> | | | 13c CITY OR TOWN <u>Balto.</u> | | | 13d INSIDE CITY - IN 1ST YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER <u>512 N. Chapelgate Lane</u> |
| 14 FATHER'S NAME First <u>UNKNOWN</u> Middle Last <u>Boughton</u> | | | | | | 15. MOTHER'S MAIDEN NAME First <u>UNKNOWN</u> Middle Last | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <u>no</u> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17 INFORMANT <u>Mr. Arthur Littlepage.</u> Address <u>22 Monclair Drive</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Antemortem - General - cerebral - cardiac</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| <u>334X Chronic rheumatoid arthritis</u> | | | | | | | | | | | |
| 19a DATE OF OPERATION <u>Jan 14, 68</u> | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>gangrene of leg</u> | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u> | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 14, 1968</u> to <u>Feb 7, 1968</u> , that (I) (we) last saw the deceased alive on <u>Feb 30</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE <u>Walter B. Buck</u> M.D. DEGREE | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | 22c DATE SIGNED <u>2/7/68</u> | | |
| 22d. PHYSICIAN'S NAME (Type) <u>WALTER B BUCK</u> | | | | | | 22e. ADDRESS <u>18 E. EAGER ST. BALTO 21202</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 23b. DATE <u>2-10-68</u> | | | 23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u> | | | 23d LOCATION (City or Town) (County) (State) <u>Balto. Md.</u> | | |
| 24. FUNERAL DIRECTOR <u>Witzke F. D., Balto., Md. 21229</u> ADDRESS <u>4101 Edmondson Avenue</u> | | | | | | 25a. REC'D BY REGISTRAR <u>FEB 8 1968</u> DATE | | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | |



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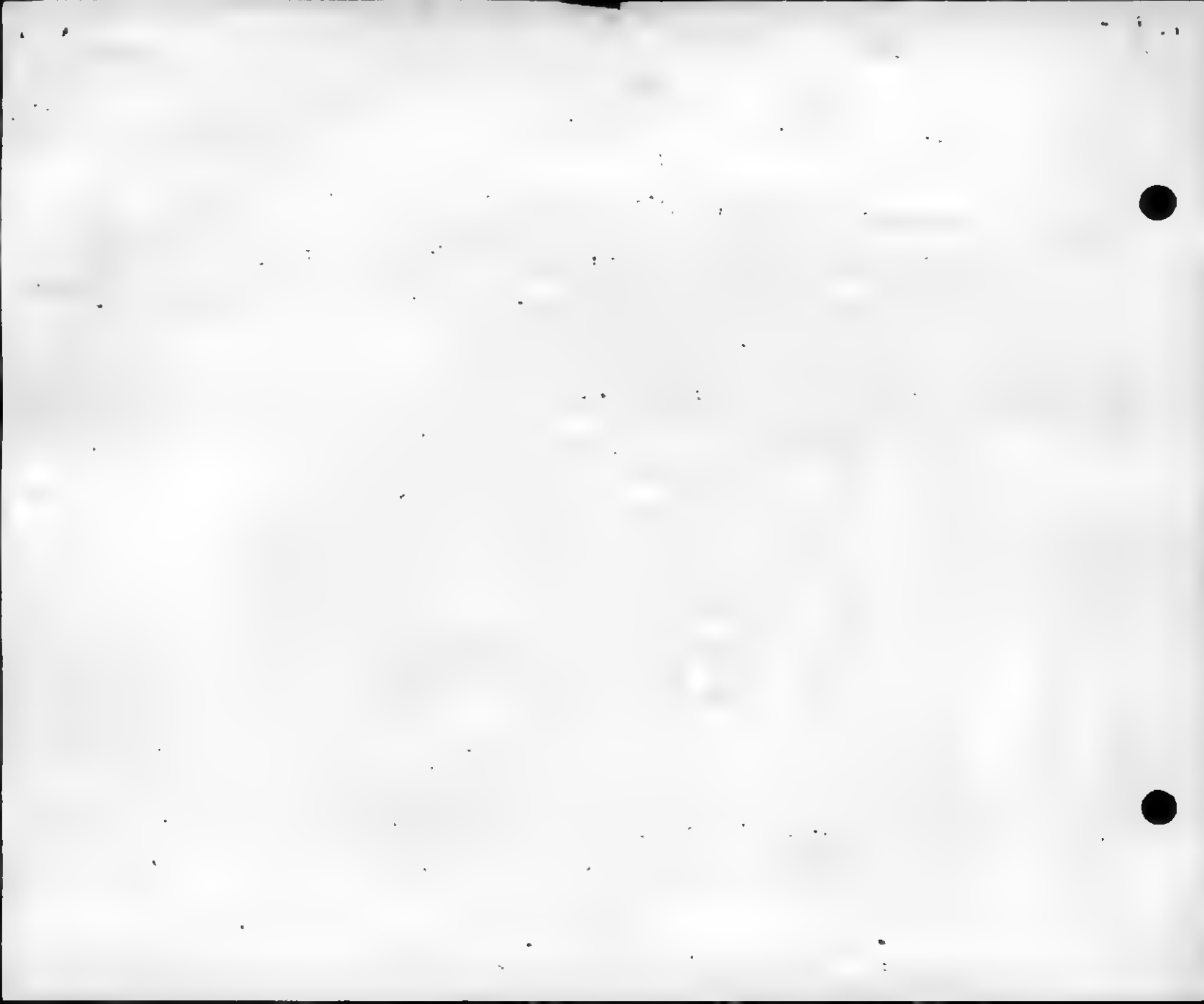
| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|---|--|---|-------|---|--|---|--|
| CERTIFICATE OF DEATH | | | | | 02248 | | | | |
| 1. DECEASED NAME
(Type or print) | | First
James | | Middle
C | | Last
Logan | | 2a. DATE OF DEATH
Month 2 Day 5 Year 68 9 54 M | |
| 3 SEX
Male | | 4 RACE
White | | 5. DATE OF BIRTH
April 18, 1899 | | 6 AGE (n years
last birthday)
68 YRS | | 7 UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH
BALTIMORE Md | | | |
| 10 CITY OR TOWN OF DEATH
Catochville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Singleton Nursing Home, Inc. | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired)
Retired | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE Md. | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Glen Burnie | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
710 Broadview Blvd | |
| 14 FATHER'S NAME
First Middle Last
Frank Logan | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Minnie (UNKNOWN) | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) No | | 16b. SOCIAL SECURITY NO.
213-07-0114 | | 17 INFORMANT
Theal M. Logan - Same as # 13e | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA, TERMINAL
1621 DUE TO, OR AS A CONSEQUENCE OF EMPYSEMA
(b) HYPERTENSIVE CARDIOVASCULAR DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) PULMONARY TBC
CONDITIONS, IF ANY, WHICH GAVE
RISE TO IMMEDIATE CAUSE (a),
STATING THE UNDERLYING CAUSE
lost. | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d. INJURY OCCURRED
White <input type="checkbox"/> Not white <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN 11, 1968, to FEB 5, 1968, that (I) (we) last
saw the deceased alive on FEB 2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
E. KASAITIS, M.D. | | DEGREE | | ATTENDING
PHYS. | | <input checked="" type="checkbox"/> MED
DIRECTOR <input type="checkbox"/> STAFF
PHYS. | | 22c. DATE SIGNED
FEB 5, 1968 | |
| 22d. PHYSICIAN'S
NAME (Type) | | E. KASAITIS, M.D. | | 22e. ADDRESS
1801 FREDERICK RD BALTO #28 | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE
2/8/1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR
Robert Plume | | ADDRESS
Singleton Funeral Home/Glen Burnie, Md. | | 25a. REC'D BY REGISTRAR
DATE FEB 7 1968 | | 25b. REGISTRAR'S SIGNATURE
Mark S. Jones | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

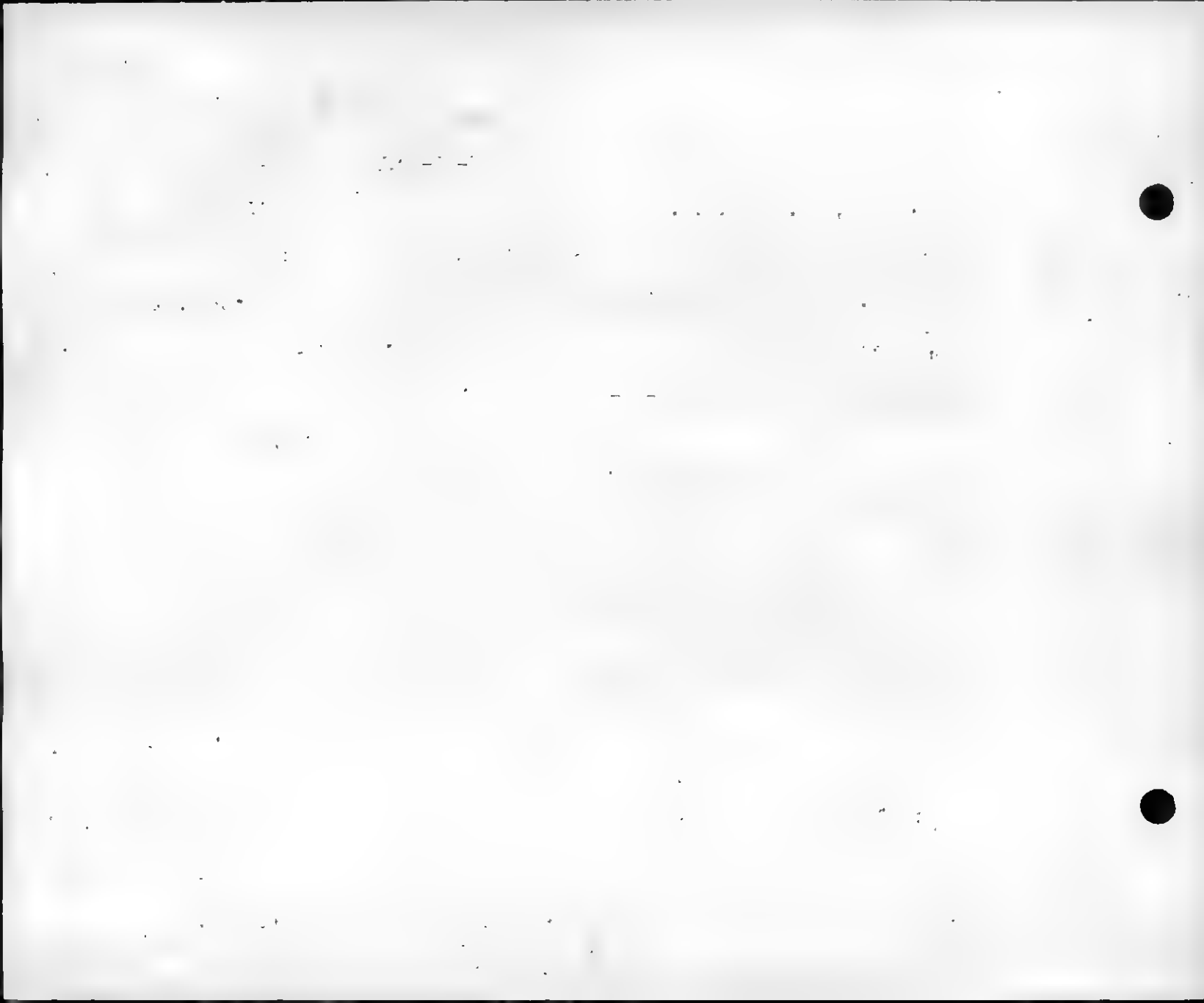
| <div style="display: flex; justify-content: space-between;"> 02261 MARYLAND STATE DEPARTMENT OF HEALTH 02264 </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 CERTIFICATE OF DEATH </div> | | | | | | | | | | | | | | | | | |
|--|--|--------|--|---|--|--|--|--|--|-----------------|--|--|--|--|--|--------------------------|--|
| 1. DECEASED-NAME (Type or print) | | | | First Middle Last | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | | | |
| Mary ONEY | | | | E. Lowenthal | | | | 2-23-68 | | | | 3:15 PM | | | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | | | 6 AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | | |
| FEMALE | | WHITE | | 3-21-89 | | | | 78 YRS | | MONTHS DAYS | | HOURS MIN | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8- MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH | | | | | |
| Maryland | | | | U.S.A. | | | | | | | | Baltimore | | Md | | | |
| 10 CITY OR TOWN OF DEATH | | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Garrison | | | | Folkleigh Nursing Home | | | | HOUSEWIFE | | | | AT HOME | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | 21208 | |
| md | | | | | | | | Baltimore | | | | YES | | 3106 Northbrook Rd. | | | |
| 14 FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | |
| George Morris | | | | Annie Felger | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | | 16b. SOCIAL SECURITY NO. | | | | 17 INFORMANT | | | | Address | | | | | |
| | | | | 220 24 2310A | | | | HARRY Lowenthal | | | | 3106 Northbrook Rd. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cerebral Vascular Accident | | | | | | | | | | | | Minutes | | | | | |
| 4369 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | unknown | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| (b) Arteriosclerosis | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 1B) | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 22, 1968, to Feb 23, 1968, that (I) (we) last saw the deceased alive on Feb 22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE David P. Miller | | | | | | | | | | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 2-23-68 | |
| 22d. PHYSICIAN'S NAME (Type) David P. Miller | | | | | | | | | | | | 22e. ADDRESS | | Lanion Rd. Annapolis, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| BURIAL | | | | 2-25-68 | | | | HEBREW FRIENDSHIP | | | | BALTIMORE, MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| 6010 REISTERSTOWN ROAD | | | | | | | | | | | | FEB 26 1968 | | [Signature] | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | |
|--|--|--------|---|---|--|---|--------------------------------|---|---|---|-----------------|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
| 1 DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | | | |
| Mary Ellen Lowry | | | | | | Feb Month 17 Day 1968 Year | | | 10-15 AM | | | | | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | | 6 AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| Female | | White | | 3-23-1889 | | | 88 78 YRS | | MONTHS DAYS | | HOURS MIN | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | |
| Frederick, Md. | | | U.S.A. | | | | | | Baltimore | | | Md | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USJA. OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Lutherville | | | College Manor Nursing Home | | | House wife | | | | | | | | |
| 13a. USJA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER | | |
| Md. | | | Baltimore | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 5103 Edmonson Ave | | |
| 14. FATHER'S NAME First Middle Last | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | |
| John William Rine | | | | | | Catherine Lease | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | Address | | | | |
| No | | | | 213-50-6979 | | Nursing Home Records | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u> | | | | | | | | | | | | minutes | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerosis</u> | | | | | | | | | | | | years | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>67</u> , to <u>Feb 17</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4/17</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE (Type) <u>William J. Furr MD</u> | | | | | | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>2/17/68</u> | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | 22e. ADDRESS | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | | | 2/20/68 | | London Park Cemetery | | | | Baltimore, Md. | | | | |
| 24. FUNERAL DIRECTOR <u>Wm. F. Tibbner & Sons</u> | | | | | | | | ADDRESS <u>Baltimore, Md.</u> | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE <u>James J. Jones</u> | | |
| | | | | | | | | DATE | | FEB 20 1968 | | | | |

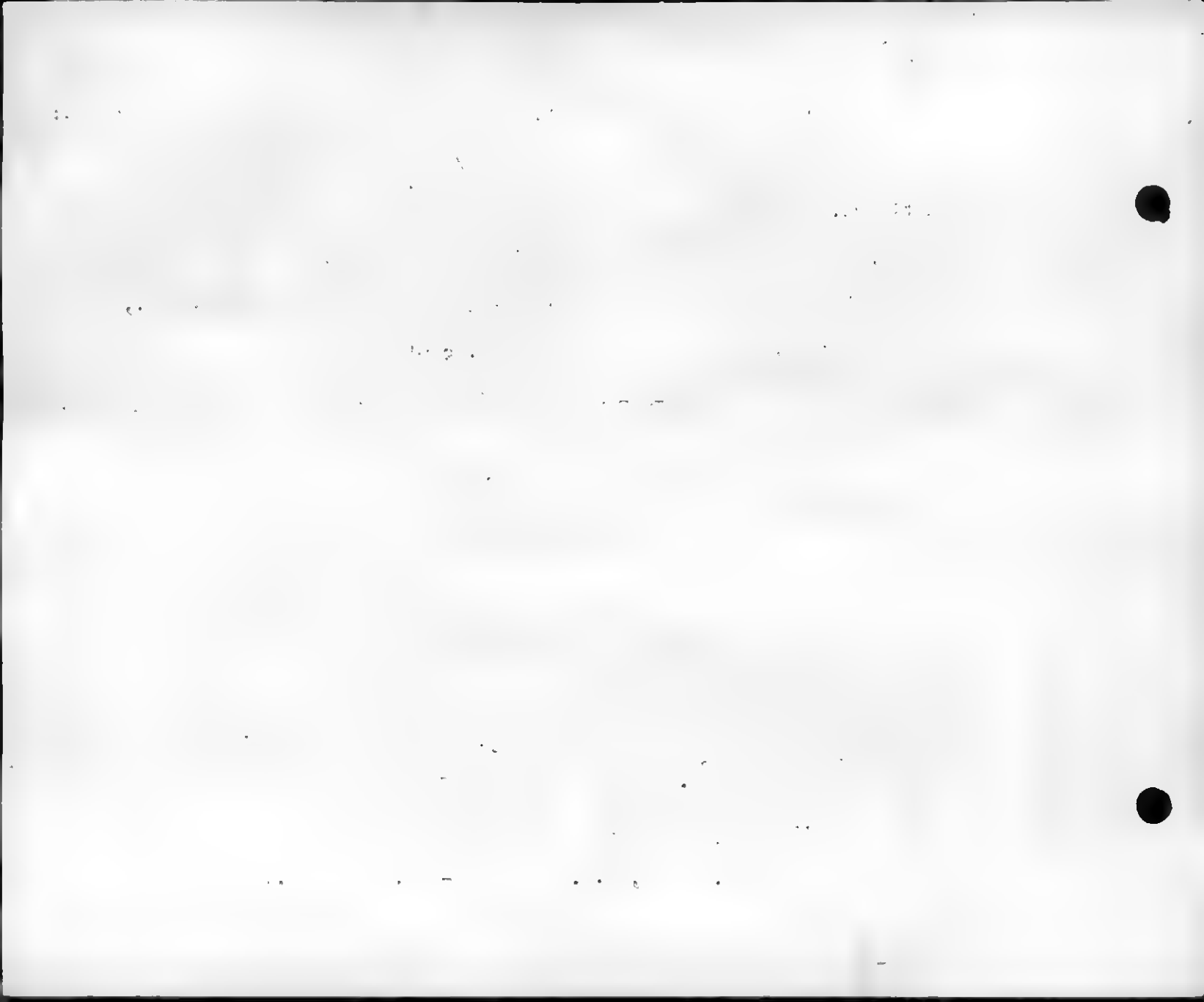


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VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|--|--|---|-----------------|--|---------|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Mary L Lynch | | | | | | Month 2 Day 3 Year 68 | | 6:50AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| F | | W | | 12/22 1879 | | 88 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Baltimore, Md | | USA | | | | Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Towson | | Stella Maris Hospice | | Clerical | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md | | | | Baltimore | | | | 3029 Kenyon Ave., | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| Daniel Lynch | | | Marie O'Donnell | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | |
| No | | | 214-22-2184 | | Hospice records | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>
DUE TO, OR AS A CONSEQUENCE OF <u>ASCVD.</u>
(b) <u>Ascorb.</u>
DUE TO, OR AS A CONSEQUENCE OF <u>Hypertension</u>
(c) <u>Hypertension</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/11/62, 19__, to 2/3/68, 19__, that (I) (we) last saw the deceased alive on 2/2/68, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Robert J. Mahon | | | | DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 2/3/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) Robert J. Mahon, M.D. | | | | 22e. ADDRESS 2-4 E. Joppa Rd., Towson | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| BURIAL | | 2/6/68 | | St. Marys Cem. | | Govans | | | |
| 24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home-6500 York Rd-21212 | | | | 25a. RECEIVED BY REGISTRAR FEB 8 1968 | | 25b. REGISTRAR'S SIGNATURE | | | |

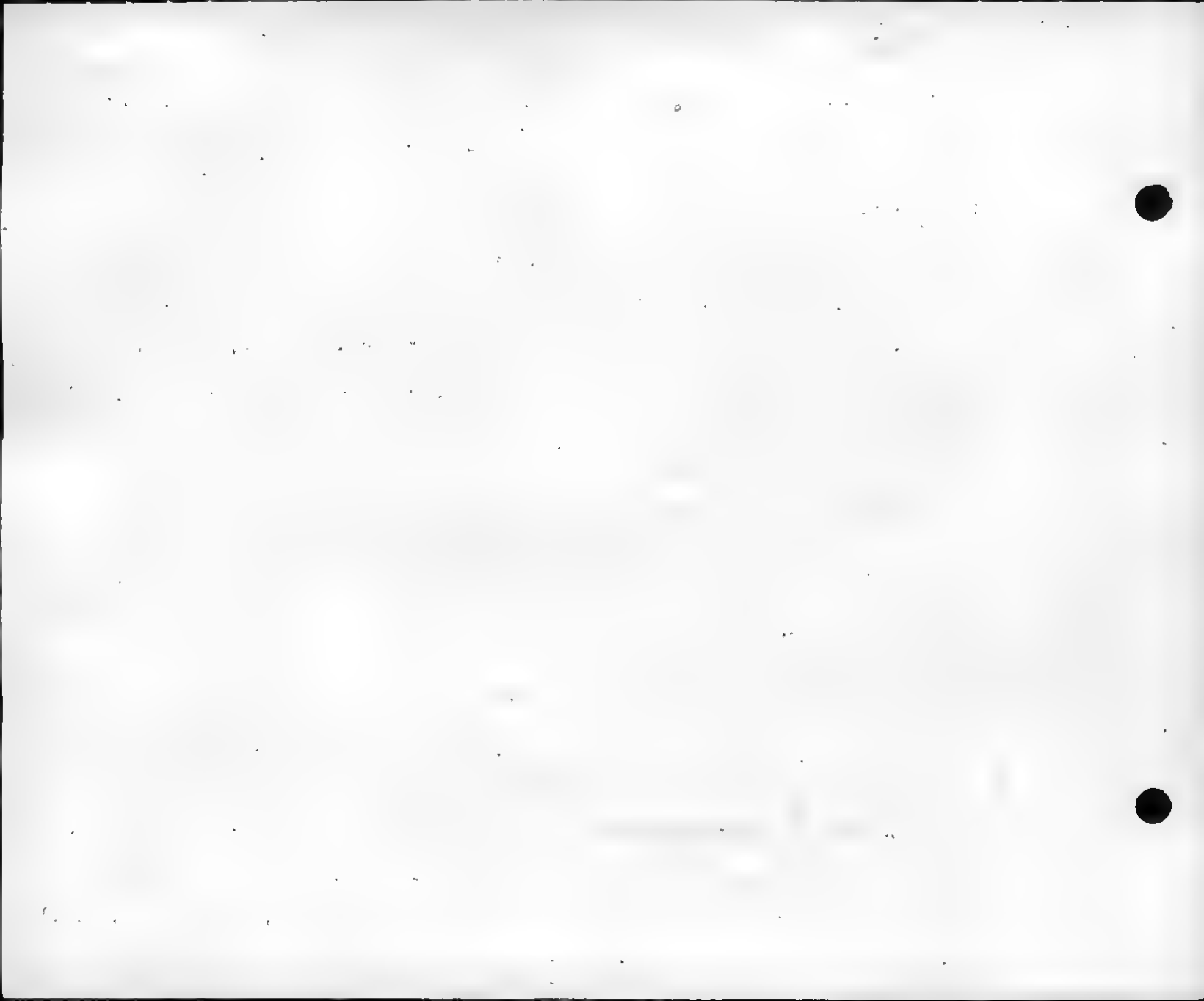


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

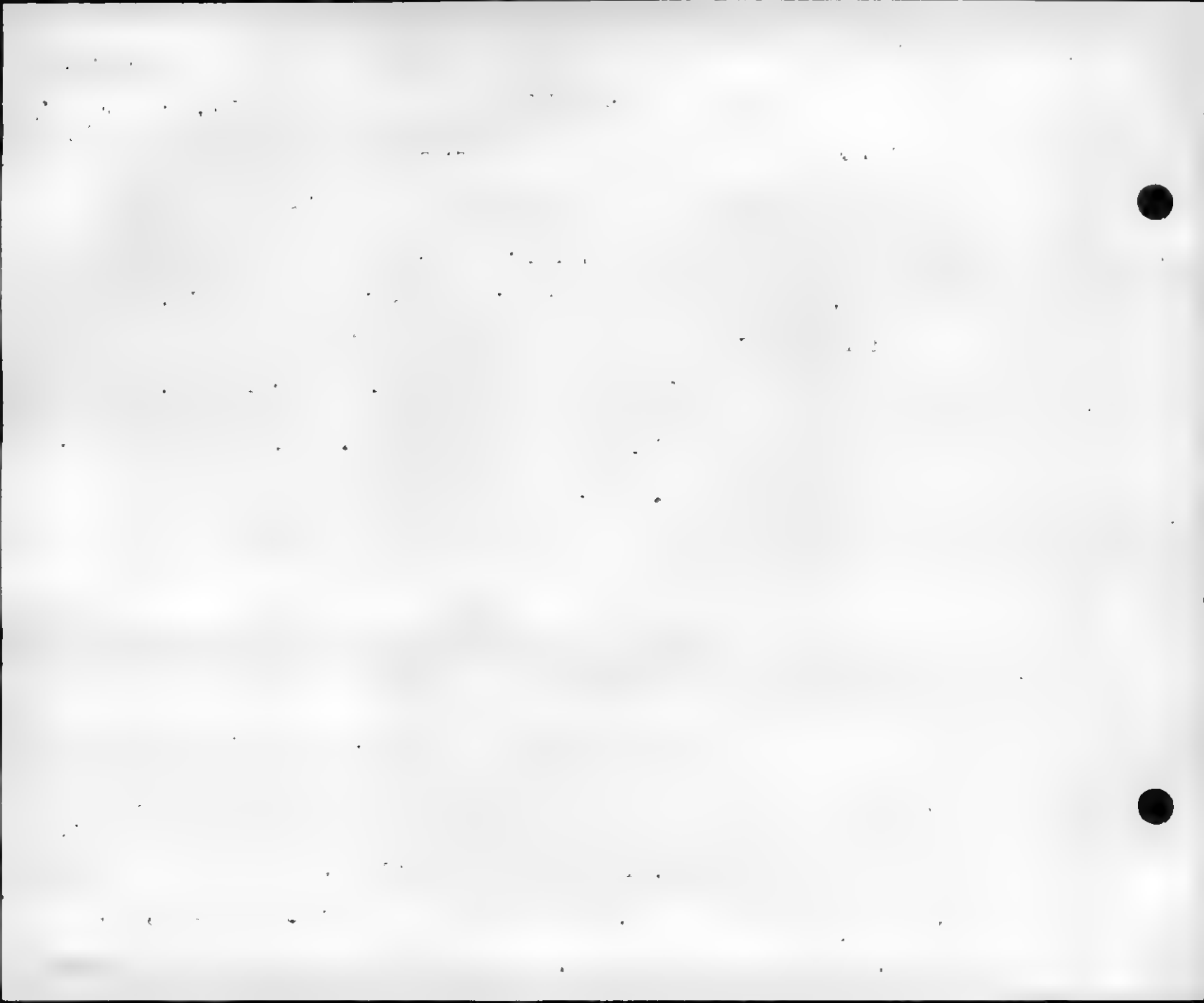
| | | | | | | | | |
|--|--|---|--------|--|---|---|----------------------------|---|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH
Month <u>2</u> Day <u>4</u> Year <u>68</u> | | 2b. HOUR
<u>5</u> A. M. | |
| 3 SEX
Female | | 4 RACE
White | | 5. DATE OF BIRTH
<u>2-22-1900</u> | | 6 AGE (In years last birthday)
<u>67</u> YRS. | | IF UNDER 1 YEAR
MONTHS <u> </u> DAYS <u> </u> |
| 7a. BIRTHPLACE (State or foreign country)
Swansea, S. Wales | | 7b. CITIZEN OF WHAT COUNTRY?
British ✓ | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md | | |
| 10 CITY OR TOWN OF DEATH
Towson | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Greater Balto Med. Center | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if instit. on. Residence before admission) STATE
Md. | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
501 Hollen Rd. 21212 |
| 14. FATHER'S NAME
First Richard Thomas Middle Last | | | | 15. MOTHER'S MAIDEN NAME
First Mary Middle Llewelyn Last | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO.
212-03-4122B | | 17 INFORMANT
Address Leslie Mac Gregor, 501 Hollen Rd. 21212 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Acute pancreatitis
DUE TO, OR AS A CONSEQUENCE OF
(b)
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | |
| 19a. DATE OF OPERATION
1/30/68 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Cholecystitis | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
yes | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. <u> </u> Month <u> </u> Day <u> </u> Year <u> </u>
P.M. <u> </u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.) | | 21f. LOCATION
Street or R.F.D. No. <u> </u> City or Town <u> </u> County <u> </u> State <u> </u> | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/14</u> , 19 <u>68</u> , to <u>2/4</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2/4</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
John E. Adams | | | | DEGREE <u> </u> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
Feb. 4, 1968 | | |
| 22d. PHYSICIAN'S NAME (Type)
John E. Adams, M.D. | | | | 22e. ADDRESS
6701 N. Charles St. Towson, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Removal-Burial | | 23b. DATE
2-10-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Tabor Chapel, | | 23d. LOCATION (City or Town) (County) (State)
Swansea, South Wales, (G.B.) | | |
| 24. FUNERAL DIRECTOR
Wm. Cook-Brooks Towson, 1050 York Rd. | | | | 25a. REC'D BY REGISTRAR
DATE FEB 9 1968 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | First | | Middle | | Last | | 2a. DATE OF DEATH
Month FEB. Day 18, Year 68 | | 2b. HOUR
4A. M |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
9-13-82 | | 6. AGE (In years
last birthday)
85 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN |
| 7a. BIRTHPLACE (State or foreign
country)
LITHUANA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE | | | | Md. |
| 10. CITY OR TOWN OF DEATH
HALETHORPE | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
4510 MAPLE AVENUE | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired)
HOMEMAKER | | 12b. K. NO. OF BUSINESS OR
INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
MD. | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
HALETHORPE | | 13d. INSIDE CITY L.M. 15?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
4510 MAPLE AVE. 21227 | | |
| 14. FATHER'S NAME
First Middle Last
PETER RAULINAITIS | | 15. MOTHER'S MAIDEN NAME
First Middle Last
GERTRUDE KURMONAVAGE | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or Unknown) NO | | 16b. SOCIAL SECURITY NO
(If yes give war or dates of service)
213508011 | | 17. INFORMANT
ANASTASIA GREEN | | Address
4510 MAPLE AVE. 21227 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1 DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u>
4-12-68 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) <u>Arteriosclerotic CVD</u>
stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF
lost. (b) (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>not</u>
<u>? yrs</u> | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street factory,
office building, etc) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 1</u> , 19 <u>65</u> , to <u>2/18</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2/15</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Herbert J. Levickas, MD</u> | | 22c. DATE SIGNED
<u>2/18/68</u> | | 22d. PHYSICIAN'S NAME (Type)
HERBERT J. LEVICKAS | | 22e. ADDRESS
5404 EAST DR. 21227 | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
BURIAL | | 23b. DATE
2-20-68 | | 23c. NAME OF CEMETERY OR CREMATORY
ST. LOUIS CEMETERY | | 23d. LOCATION (City or Town) (County) (State)
FRACKVILLE, PA. | | | | |
| 24. FUNERAL DIRECTOR
HOWARD H. HUBBARD | | ADDRESS
4107 WILKENS AVE. 21229 | | 25a. REC'D BY REGISTRAR
DATE FEB 20 1968 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Young</u> | | | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the death certificate. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|------------------------|--|--|--|--|--|--|---|--|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1 DECEASED NAME
(Type or Print) Harold | | | First Middle Last | | | 2a DATE KNOWN OF DEATH 2 14 1968 | | | 2b HOUR 8:35 A | | |
| 3 SEX
Male | 4 RACE
White | 5 DATE OF BIRTH
June 4, 1907 | 6 AGE (in years last birthday)
60 YRS. | F UNDER 1 YEAR
MONTHS DAYS | | F UNDER 24 HRS
HOURS MIN. | | 2c DATE PRONOUNCED DEAD
Month Day Year 2 14 1968 | | 2d HOUR 8:00 A | |
| 7a BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH
Baltimore | | | | | |
| 10 CITY OR TOWN OF DEATH
Sparrows Point | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Plant Dispensary | | | 12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired)
Shipyard worker | | | 12b KIND OF BUSINESS OR INDUSTRY
Shipbldg. | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Md. | | | 13b COUNTY Baltimore | | | 13c CITY OR TOWN Baltimore | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER
236 S. Mount St 21223 | |
| 14 FATHER'S NAME First Middle Last
Perry Markley | | | | 15 MOTHER'S MAIDEN NAME First Middle Last
Unknown | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ? | | | 16b SOCIAL SECURITY NO ? | | | 17 INFORMANT ADDRESS
Mrs. Harold Markley - Wife - Above | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: Coronary Occlusion | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) 4 1 1 7 | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 4 2 2 1 N | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? E | | | | 20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. 19
P.M. OP.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. E | | City or Town | | County | | State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE M B Davis | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b DATE SIGNED 2/14/68 | | | |
| EXAMINER'S NAME (Type) Melvin B. Davis, M.D. | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | ADDRESS (Street, city, town, or county) Lundale, Md. 21222 | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE 2-17-68 | | 23c NAME OF CEMETERY OR CREMATORY Feltonburg | | 23d LOCATION (City or Town) Feltonburg | | County W. Va. | | State | |
| 24 FUNERAL DIRECTOR Arthur A. Haight | | | | ADDRESS Hydram, Md. | | | | 25a REC'D BY REGISTRAR FEB 16 1968 | | 25b REGISTRAR'S SIGNATURE Charles J. Jones | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY BALTO. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MD b. COUNTY BALTO | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ESSEX | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ESSEX | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6 DOROTHY AVE | | d. STREET ADDRESS 6 DOROTHY AVE | |
| 3. NAME OF DECEASED (Type or print) ELIZABETH MARKS | | 4. DATE OF DEATH FEB 10 1968 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6/10/12 |
| 9. AGE (In years last birthday) 55 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) BALTO. MD | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME ROSINSKI | | 14. MOTHER'S MAIDEN NAME ? | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) N/O | | 16. SOCIAL SECURITY NO. GEORGE MARKS | |
| 17. INFORMANT ABOVE | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis, toxemia
DUE TO (b) Carcinoma of Sigmoid
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
2 yrs
5 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1966 to 2-10, 1968 , that (I) (we) last saw the deceased alive on 2/9, 1968 , and that death occurred at 3 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE M. B. Cunningham M.D. | | 22b. DATE SIGNED 2/10/68 | |
| 22c. PHYSICIAN'S NAME (Type) Balto 212-37 | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 2/14/68 | 23c. NAME OF CEMETERY OR CREMATORY OAK LAWN | 23d. LOCATION (City, town or county) (State) BALTO. MD |
| 24. FUNERAL DIRECTOR J. E. CONNELLY SONS ADDRESS 300 MACE | | 25a. REC'D BY REGISTRAR FEB 11 1968 25b. REGISTRAR'S SIGNATURE | |

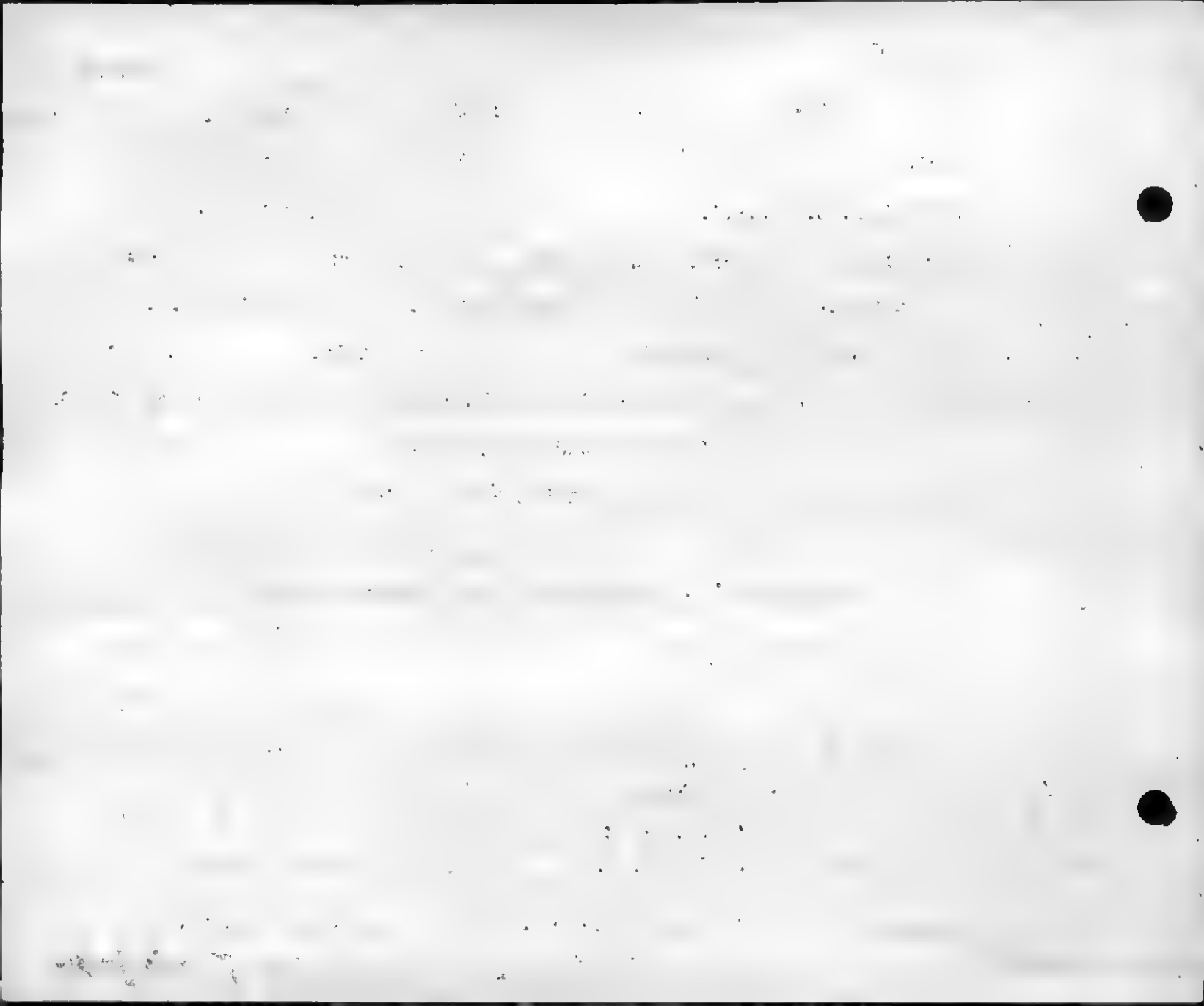


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|--|--------------------------------------|---|--|---|--|--|--|
| 02268
CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED NAME
(Type or print) | | | First Middle Last
JOSEPH MARSHALL | | | 2a. DATE OF DEATH
Month Day Year
FEBRUARY 14 1968 | | 2b. HOUR
9:40 AM | |
| 3 SEX
MALE | | 4 RACE
NEGRO | | 5. DATE OF BIRTH
3/2/95 | | 6 AGE (In years
last birthday)
72 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS M'N | |
| 7a. BIRTHPLACE (State or foreign
country)
WASHINGTON, D. C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE COUNTY, Md | | | |
| 10 CITY OR TOWN OF DEATH
FORT HOWARD | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
VET. ADM. HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired)
LABORER | | 12b. KIND OF BUSINESS OR
INDUSTRY
CONSTRUCTION | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before
admission) STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
1214 Edison Hwy. | |
| 14. FATHER'S NAME
First Middle Last
WESLEY MARSHALL | | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
LOUISE JOHNSON | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
YES | | 16b. SOCIAL SECURITY NO.
WW 1 | | 17. INFORMANT
CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | Address | | | |
| 18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>RECENT MYOCARDIAL INFARCTION</u>
4100 DUE TO, OR AS A CONSEQUENCE OF
(b) <u>ARTERIOSCLEROTIC HEART DISEASE</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>4211</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>CHRONIC PYELONEPHRITIS. HYPERTENSIVE CARDIOVASCULAR DISEASE</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH?
YES | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/13/68</u> , 19 <u>68</u> , to <u>2/14/68</u> , 19 <u>68</u> , that (I) (we) last
saw the deceased alive on <u>2/14/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the
cause(s) stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Rodolfo G. Miro</i> | | DEGREE | | ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/14/68 | | | |
| 22d. PHYSICIAN'S
NAME (Type)
RODOLFO G. MIRO, M. D. | | 22e. ADDRESS
VAH FORT HOWARD, MARYLAND | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
BURIAL | | 23b. DATE
2-19-68 | | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE NATIONAL | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MD. | | | |
| 24. FUNERAL DIRECTOR
<i>Ernest O. Wilson</i> | | ADDRESS
WILSON FUNERAL HOME
ORLEANS STREET, BALTIMORE, MD. | | 25a. REC'D BY REGISTRAR
DATE FEB 15 1968 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

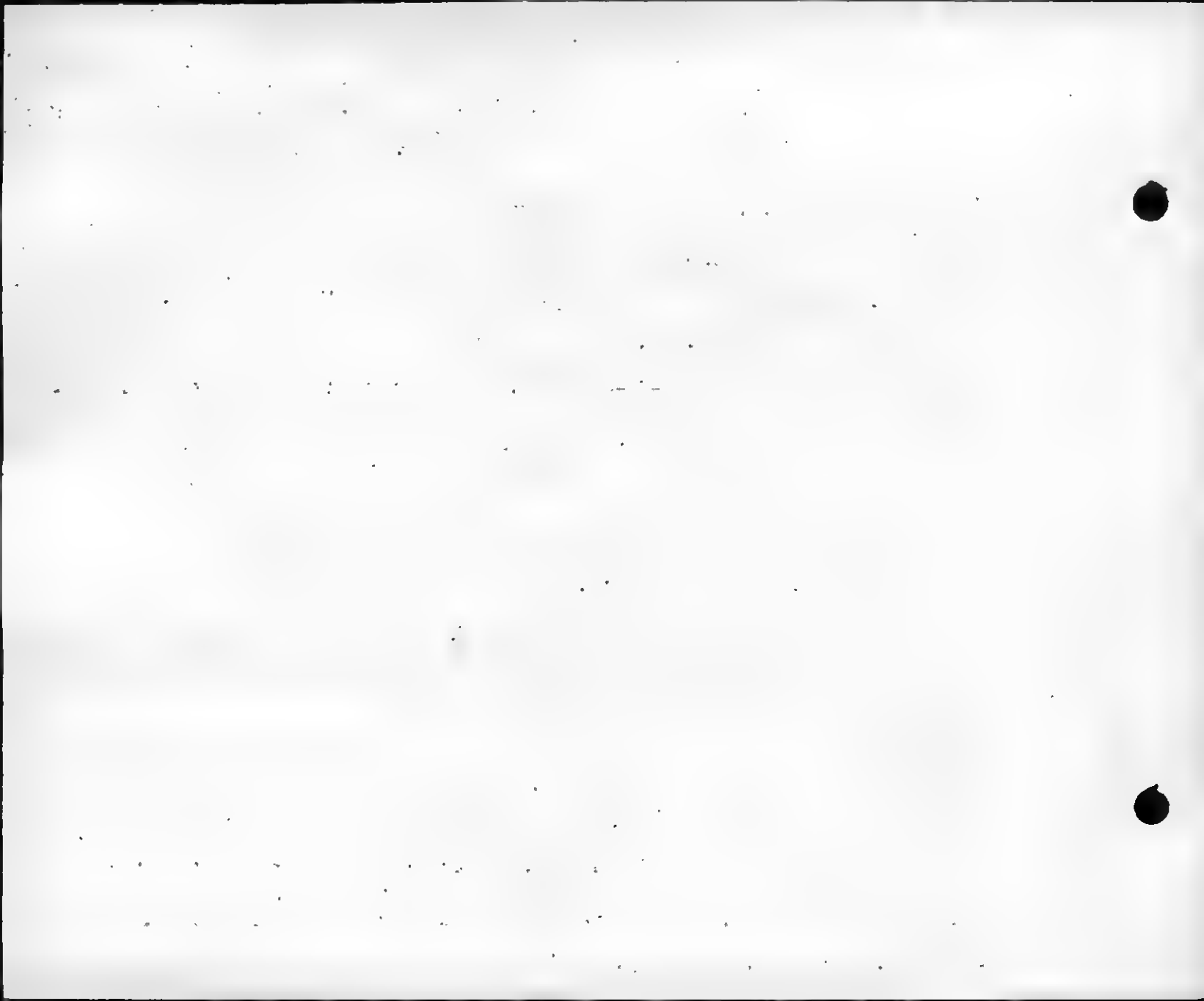
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

3226)

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | |
|---|--|---|--|--|--|--|---|--|--|---|-------|--|--|
| 1 DECEASED-NAME
(Type or print) | | First ANNA (Annie) | | Middle | Last MASCHERONI | | 2a DATE OF DEATH
Month February Day 5 Year 1968 | | 2b HOUR
7:25 PM | | | | |
| 3 SEX
Female | | 4 RACE
White | | 5 DATE OF BIRTH
8/17/1892 | | | 6 AGE (In years
last birthday)
75 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | | | |
| 7a BIRTHPLACE (State or foreign
country)
Italy | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | | | |
| 10 CITY OR TOWN OF DEATH
Towson | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
St. Joseph Hospital | | | 12a USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Homemaker | | | 12b KIND OF BUSINESS OR
INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution
admission) STATE Maryland | | 13b. COUNTY
Baltimore | | 13c CITY OR TOWN
Baltimore | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER
1701 Ingram Rd. | | | | | |
| 14 FATHER'S NAME
First ? Middle ? Last Merenda | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Unknown | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
218-07-6668 | | 17. INFORMANT
Mr. Alfred Maskeroni, 1717 Ingram Rd. 21214 Address | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Pulmonary thrombo-embolism
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
(c) _____
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. 465x
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Carcinoma of stomach with metastases | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | | |
| 21a ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f LOCATION Street or RFD No | | City or Town | | County | | State | | |
| 22a I certify that (1) (this hospital) attended the deceased from January 27, 1968, to February 5, 1968, that (1) (we) last
saw the deceased alive on February 5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above. (4) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b SIGNATURE
Reynaldo Orjuela-Gomez, M.D. | | | | | | | | | | 22c DATE SIGNED
February 6, 1968 | | | |
| 22d PHYSICIAN'S
NAME (Type) | | | | | | | | | | 22e ADDRESS
7620 York Rd., Towson, Md. 21204 | | | |
| 23a BURIAL, CREMATION,
REMOVAL (Specify) | | 23b DATE
2/10/68. | | 23c NAME OF CEMETERY OR CREMATORY
Gardens of Faith Cemetery | | | 23d LOCATION (City or Town)
Baltimore, Md. | | (County) (State) | | | | |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Balto. Md. 21214 ADDRESS | | | | | | | | | | 25a. REC'D BY REGISTRAR
DATE FEB 8 1968 | | 25b REGISTRAR'S SIGNATURE
Charles Judge | |

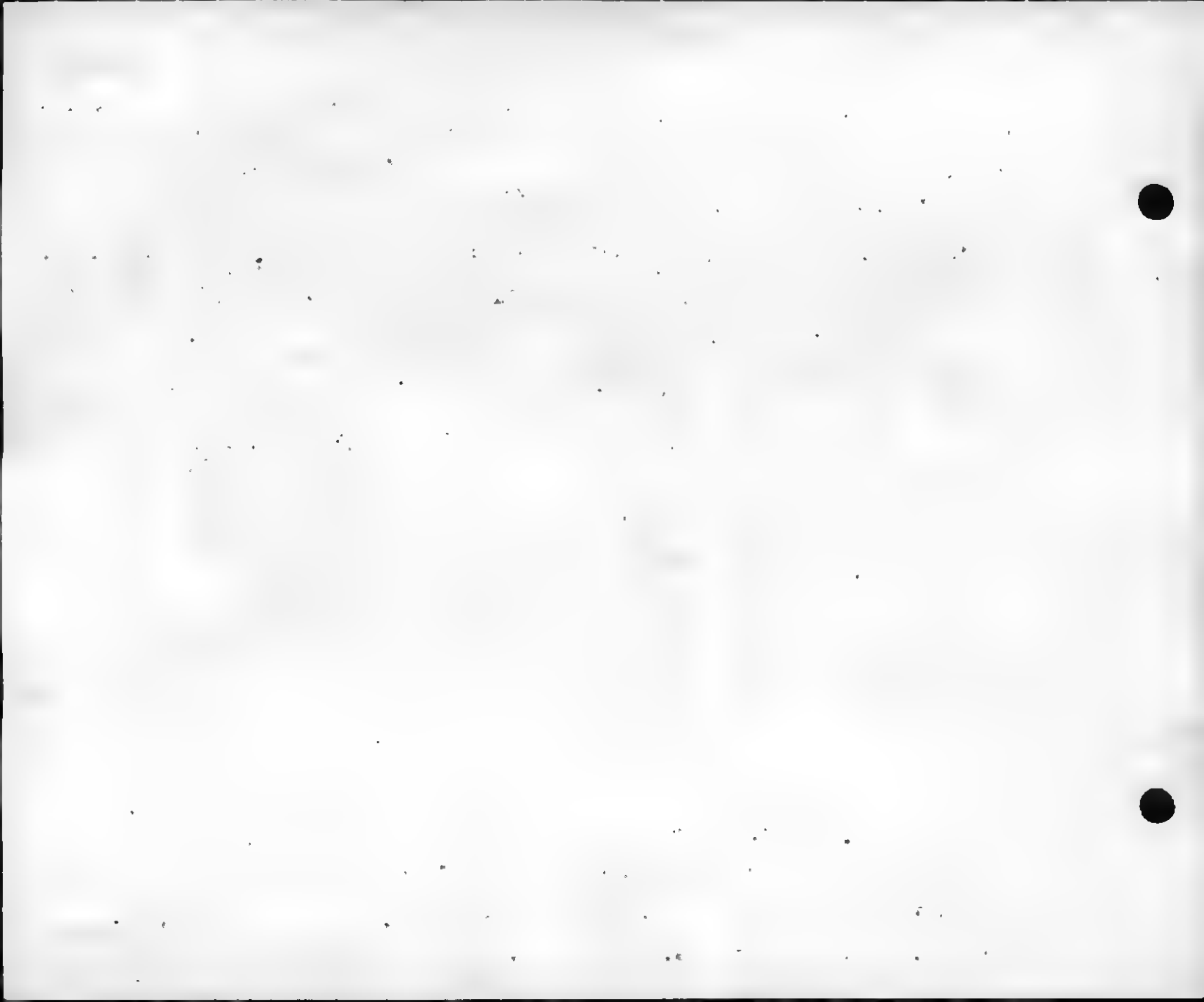
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

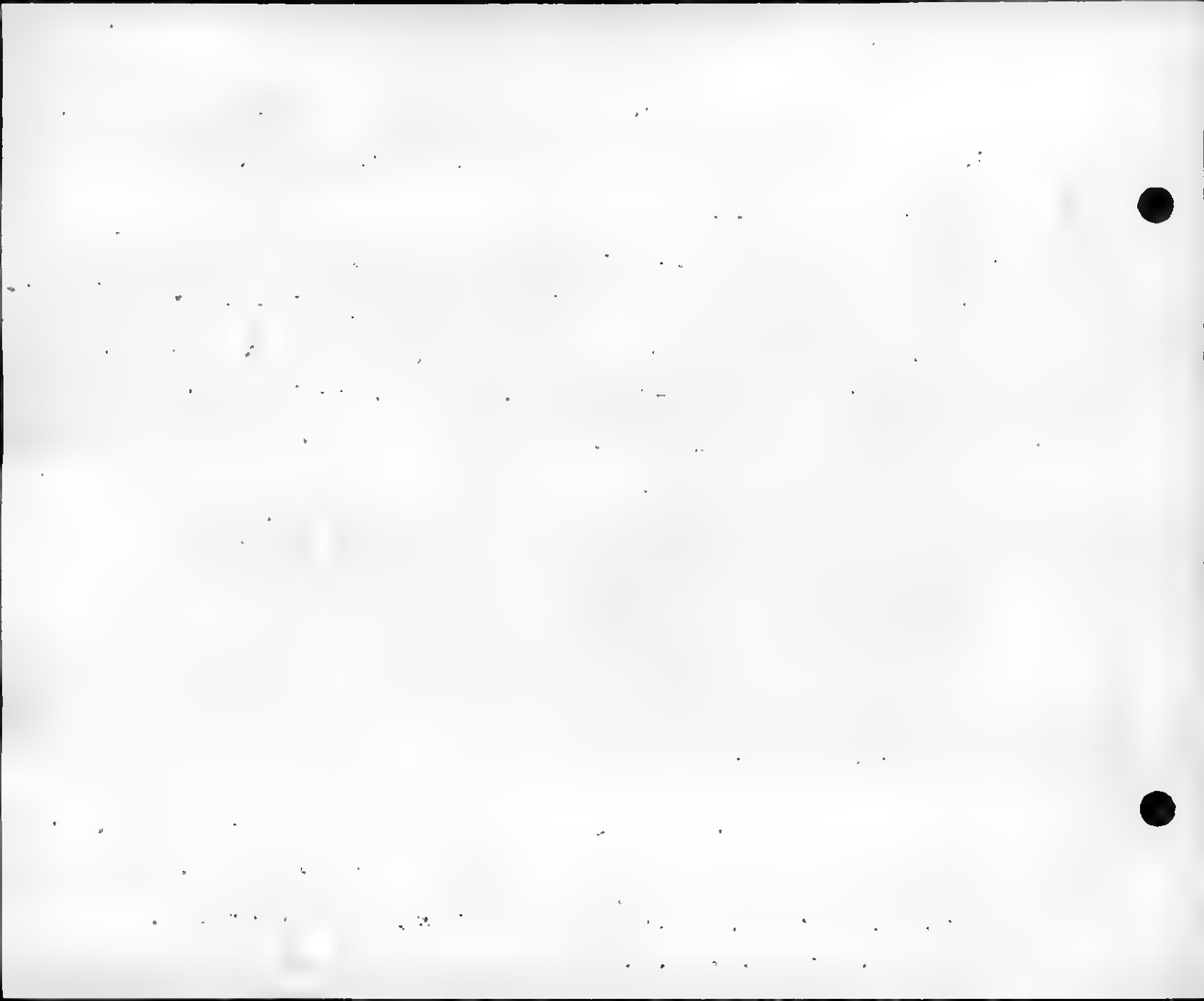
| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|---|---|--|--|---------------------------------|---|---|------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | First | | Middle | | Last | | 2a. DATE OF DEATH | | | 2b. HOUR |
| LEN WOOD | | BLAIR | | MASINCUPP | | February 16, 1968 | | | 6:20 AM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | 7. UNDER 1 YEAR | | IF UNDER 24 HRS. |
| male | | white | | 8/12/1908 | | | 59 YRS. | | MONTHS | | DAYS |
| 7a. BIRTH-PLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| VIRGINIA | | U.S.A. | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Baltimore County, Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Mount Wilson | | | Mt. Wilson State Hospital | | | surgeon | | | Balto. Co. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution on: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER |
| MD | | | Baltimore | | | Dundalk | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 3006 Saffers Point Rd. |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | |
| Tuckin | | | Masincupp | | | Nannie Rohrer | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | | | |
| No | | | 213-09-1762 | | | Records, Mt. Wilson State Hospital | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Ca of the lung. (out cell)</u> | | | | | | | | | | | |
| 1621 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) _____ | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) _____ | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| <u>Pulmonary Tuberculosis</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| | | HOUR A.M. Month Day Year | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | | County State | |
| While <input type="checkbox"/> at work | | Night <input type="checkbox"/> at work | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/16/1967</u> to <u>2/16/1968</u> , that (I) (we) last saw the deceased alive on <u>2/16/1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | |
| <u>W. Newcomer</u> | | | | | | | | | | 2/16/68 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | |
| Wm. Newcomer, M.D. | | | | | | Mount Wilson, Maryland | | | | | |
| 23a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | 2/20/68 | | Meadowridge Memorial Pk. | | Dorsey, Md. | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | | 25a. RECEIVED BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| John J. Duda, 7922 Wise Ave. Dundalk, Md. | | | | | | FEB 19 1968 | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon pages 3 and 4 and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|--|---|--|---|---|---|--|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
Colette | | Middle
M. | | Last
MASKELL | | 2a. DATE OF DEATH
Month February Day 21 Year 1968 | |
| 3 SEX
Female | | | 4 RACE
White | | 5. DATE OF BIRTH
August 24, 1900 | | | 6 AGE (In years last birthday)
67 YRS. | | 2b. HOUR
2:30PM |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore, Md. | | | |
| 10 CITY OR TOWN OF DEATH
Towson | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
ST. JOSEPH HOSPITAL | | | 12a. OCCUPATION (Kind of work done during most of working life, even if retired.)
Homemaker | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before address on) STATE
Maryland | | | 13b. COUNTY
Baltimore | | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
3109 Gibbons Ave.
2084 Echodale Ave. |
| 14. FATHER'S NAME | | | First
Kinlein | | Middle
 | | Last
 | | 15. MOTHER'S MAIDEN NAME First
Dorothea Middle
Stengel Last
 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) NO | | | 16b. SOCIAL SECURITY NO
(If yes give war or dates of service)
219-50-9022 | | 17 INFORMANT
Mr. Kenneth T. Maskell | | | Address
(Same) | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute pyelonephritis
DUE TO, OR AS A CONSEQUENCE OF
(b) Obstructive uropathy
DUE TO, OR AS A CONSEQUENCE OF
(c) Calculi in left renal pelvis & blood clot in rt. ureter | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Thrombocytopenic purpura | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County State |
| 22a. I certify that (X) (this hospital) attended the deceased from 2/8/ 19 68 , to 2/21/ 19 68 , that (X) (we) last saw the deceased alive on 2/21/ 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Samuel J. Maskell | | | | | | | | DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
February 21, 1968 |
| 22d. PHYSICIAN'S NAME (Type)
 | | | | | | 22e. ADDRESS
7620 York Rd., Towson, Md. 21204 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Entombment | | | 23b. DATE
2/21/68. | | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Mausoleum | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | | |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Balto. Md. 21211 | | | | | | 25a. REC'D BY REGISTRAR
DATE FEB 23 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles J. J... | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | |
|---|--|---|--|--|---|
| 1 DECEASED-NAME
(Type or print) First Middle Last
FRANK WILLIS MATTHEWS | | 2a. DATE OF DEATH
Month Day Year
2 / 18 / 1968 | | 2b. HOUR
7.30 AM | |
| 3 SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
10/19/1895 | |
| 6 AGE (in years
last birthday)
72 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign
country)
Michigan | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9 COUNTY OF DEATH
Baltimore County | | Md. | | | |
| 10 CITY OR TOWN OF DEATH
Mt. Wilson | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Mt. Wilson State Hosp. | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
factory worker | |
| 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution
admission) STATE
MD. | | 13b. COUNTY
Carolina | | 13c. CITY OR TOWN
Ridgely | |
| 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
101 Maple Ave. | | | |
| 14. FATHER'S NAME First Middle Last
Leland Matthews | | 15. MOTHER'S MAIDEN NAME First Middle Last
MARTHA ROSINA Powers | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) (If yes give war or dates of service)
No | | 16b. SOCIAL SECURITY NO
213-01-5555 | | 17 INFORMANT Address
Records, Mt. Wilson State Hospital | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cancer of the lung
1621
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
1621X Pulmonary Tuberculosis | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory)
OFFICE BUILDING, ETC. | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/21/1967 to 2/18/1968 , that (I) (we) lost
saw the deceased alive on 2/18/1968 , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
W Newcomer | | DEGREE ATTENDING <input type="checkbox"/> MED <input checked="" type="checkbox"/> STAFF <input type="checkbox"/>
PHYS PHYS DIRECTOR PHYS | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S
NAME (Type) William Newcomer, M.D. | | 22e. ADDRESS
Mount Wilson, Maryland | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
2-21-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Ridgely | |
| 23d. LOCATION (City or Town) (County) (State)
Ridgely Carolina Md. | | | | | |
| 24. FUNERAL DIRECTOR
Miss Louise's | | ADDRESS
Baltimore | | 25a. REC'D BY REG STRAR
DATE FEB 23 1968 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |



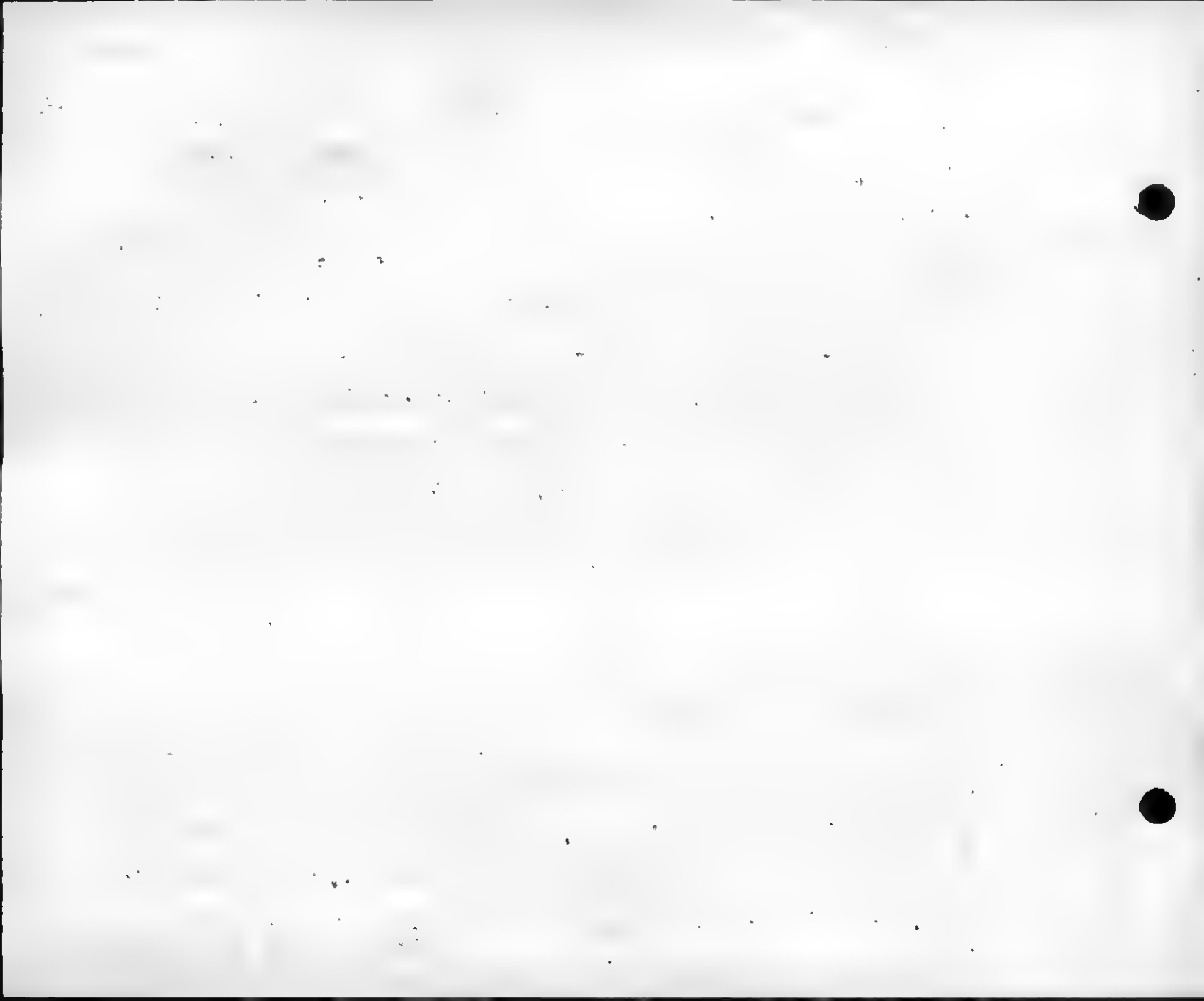
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151
304A REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1 DECEASED-NAME
(Type or print) | | First Middle Last | | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR
7:45 A.M. | |
| Cornelia | | MAYNOR | | February 13, 1968 | | | |
| 3 SEX
Female | | 4 RACE
Negro | | 5 DATE OF BIRTH
October 18, 1894 | | 6 AGE (In years last birthday)
73 | |
| 7a BIRTHPLACE (State or foreign country)
North Carolina | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH
Baltimore, Md. | |
| 10 CITY OR TOWN OF DEATH
Towson | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
ST. JOSEPH HOSPITAL | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Homemaker | | 12b KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE
Maryland | | 13b COUNTY
Baltimore | | 13c INS. OR CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER
459 Schwartz Ave. | |
| 14. FATHER'S NAME
First Middle Last
John Lewis | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Aussie | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
No | | 16b SOCIAL SECURITY NO.
Unknown | | 17 INFORMANT
Ethel Exum - 832 Whitmore Ave. Sacto. 12 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Gastro-intestinal bleeding, chronic</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Intestinal tumor, probably malignant.</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) | | | |
| 21a INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/31/</u> 19 <u>68</u> , to <u>2/13/</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2/13/</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE
Jaime Punzalan, M.D. | | | | DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22c DATE SIGNED
February 13, 1968 | |
| 22d. PHYSICIAN'S NAME (Type)
Jaime Punzalan | | 22e ADDRESS
7620 York Rd., Towson, Md. 21204 | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE
2/16/68 | | 23c NAME OF CEMETERY OR CREMATORY
Carver Mem. Pk. | | 23d LOCATION (City or Town) (County) (State)
Towson, Md. | |
| 24. FUNERAL DIRECTOR
Wm. L. Chaturian | | ADDRESS
1701 M. C. St. | | 25a. REC'D BY REGISTRAR
FEB 19 1968 | | 25b. REGISTRAR'S SIGNATURE
James Judge | |



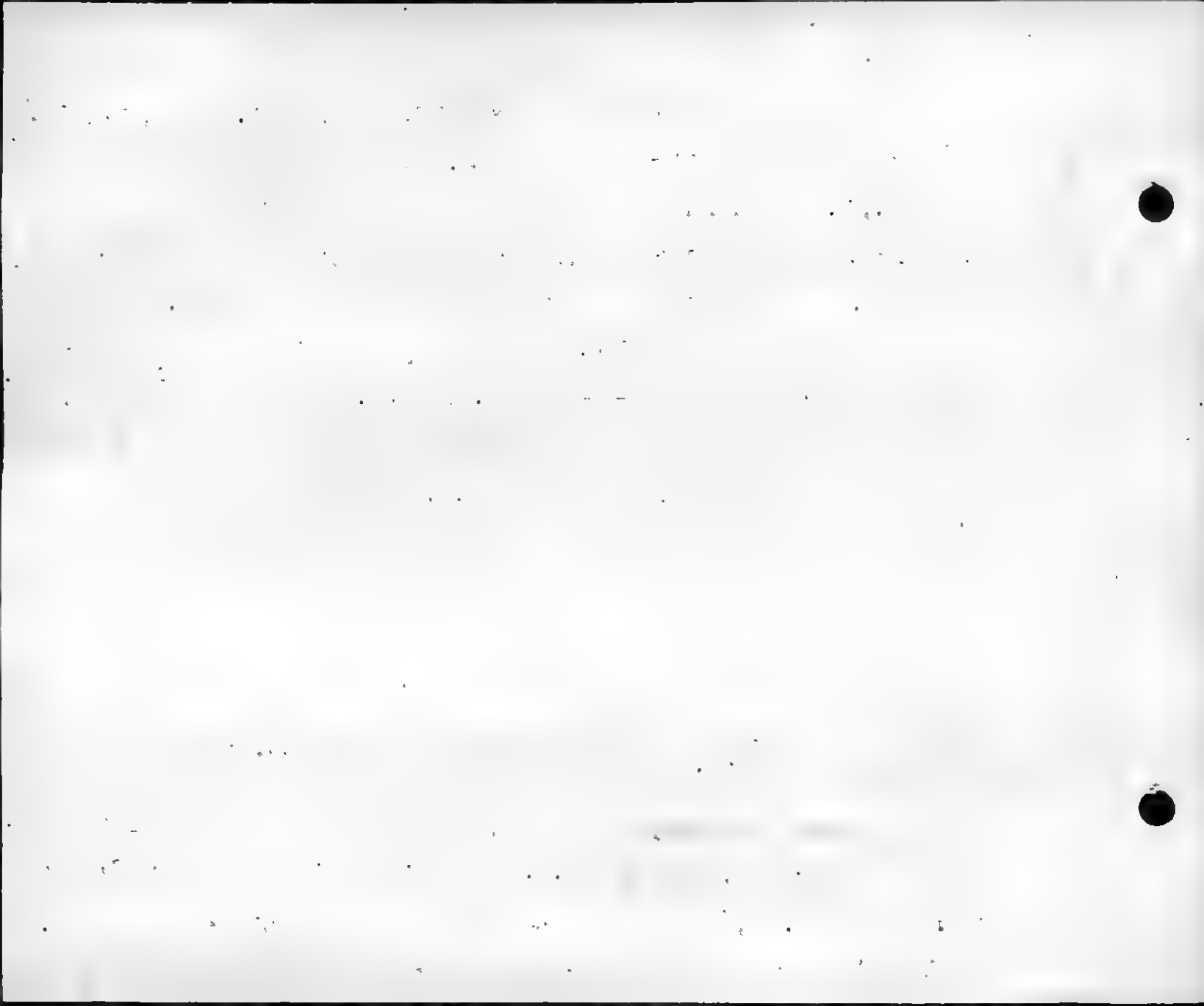
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | |
|--|------------------------------|--|---|--|-------------------------------------|--|--------------------------------|------------------------|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR
P. M. | |
| Leo | | LeRoy | McConville | Feb. 15, 1968 | | 7 P. | | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | 7. UNDER 1 YEAR
MONTHS DAYS | |
| Male | White | | Dec. 10, 1900 | | 67 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Baltio., Md. | U.S.A. | | | | Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USAL OCCUPATION (Kind of work done during most of work ng life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| reisterstown | | 101 W. Main St., Reisterstown, Md. | | Farmer | | | | |
| 13a. USAL RESIDENCE (Where deceased lived, if instituton: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER |
| Md. | | Baltimore | | Reisterstown | | | | 101 Main St. |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | |
| Unknown | | | Unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, go, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | |
| No | | 0-4-14-3420 | | Mrs. Evelyn A. McConville | | 101 Main St., Reisterstown, Md. | | |
| 18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral vascular accident
4127 DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerotic C.V. Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 days
years | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM STREET FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 6, 1965, to Feb. 18, 1968, that (I) (we) last saw the deceased alive on Feb. 18, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | | |
| Martin E. Strobel | | | | | | 2-20-68 | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | |
| Martin E. Strobel, M.D. | | 59 Hanover Rd. Reisterstown, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| ENTOMBMENT | | Feb. 20, 1968 | | Western Cemetery | | Baltimore Md. | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Frank H. Newell | | Pikesville, Md. | | FEB 21 1968 | | [Signature] | | |

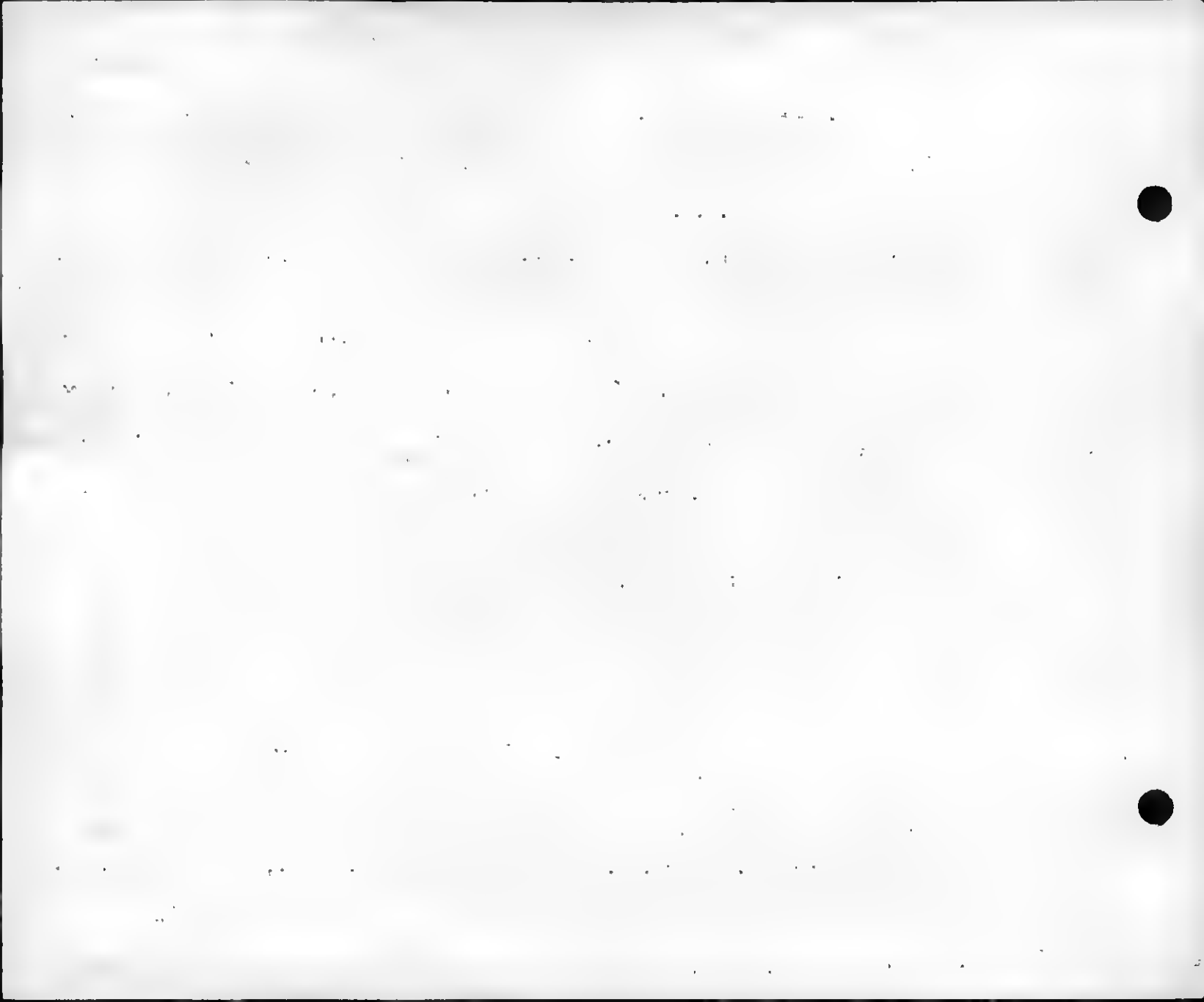


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper Pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | | |
|--|------------------------------|--|--|--|---------------------------------|--|-----------------------------|--|--|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | | 2b. HOUR | | |
| Thomas | | T. | | McCORMICK | Month 2 Day 20 Year 68 | | 6:50 ^a M | | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | |
| Male | White | | 1/11/08 | | 60 YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | 10. CITY OR TOWN OF DEATH | | |
| Maryland | U.S.A. | | | | Baltimore | | Owings Mills | | |
| 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. USUAL RESIDENCE (Where deceased lived, if not in hospital give street address) | | 13b. COUNTY | |
| Rosewood State Hospital | | Farmhand | | none | | Maryland | | Allegany | |
| 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | 13f. CITY OR TOWN | | 13g. COUNTY | |
| Lonaconing | | | | 134 Frederick Street | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT | |
| David | | Isabelle | | no | | #214-36-8434 | | Rosewood Records, Owings Mills, Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis, Acute</u> | | DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arterio-sclerosis, Generalized</u> | | DUE TO, OR AS A CONSEQUENCE OF (c) <u>4201</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | Few Minutes | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Congenital Moron, Etiology Not Determined</u> | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC | |
| 21f. LOCATION Street or R.F.D. No | | City or Town | | County | | State | | | |
| 22a. I certify that (this hospital) attended the deceased from 5/8, 1924, to 2/20, 1968, that (we) last saw the deceased alive on 2/20, 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (if (we) (did) (did not) view the body after death. | | 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | |
| Harry G. Butler M.D. | | 2/21/68 | | Harry G. Butler, M.D. | | Rosewood St. Hospl, Owings Mills, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | 23e. REC'D BY REGISTRAR | |
| Burial | | Feb. 26, 68 | | Rosewood Cemetery | | Owings Mills, Md. | | DA FEB 28 1968 | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REGISTRAR'S SIGNATURE | | 25b. REGISTRAR'S SIGNATURE | | | |
| J. F. Eline & Sons | | Reisterstown, Md. | | Charles Judge | | | | | |

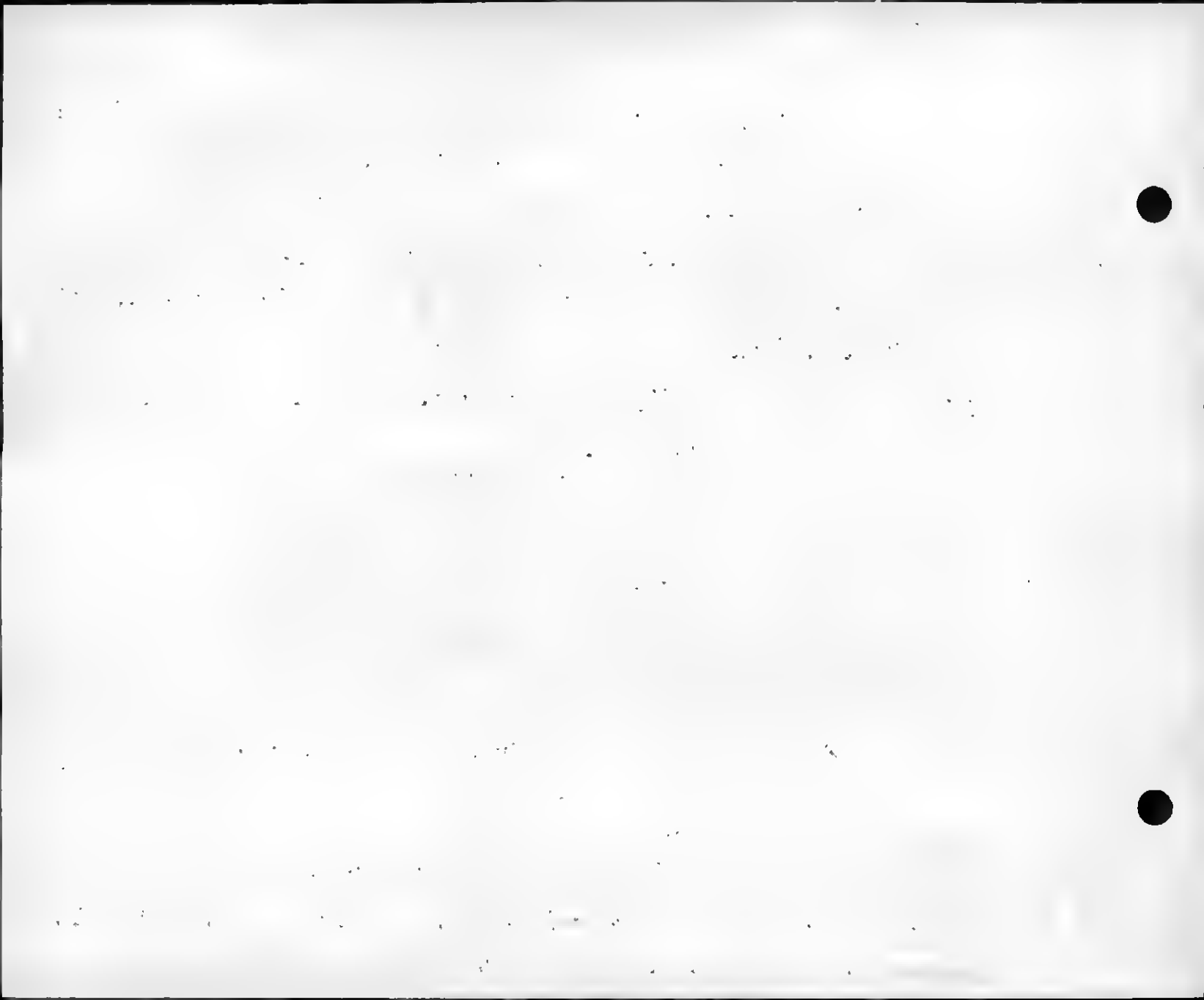


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician and completely filled in by the attending physician and completely filled in by the funeral director. Pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|---|--|--|--|--|--|------------------------------------|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED NAME (Type or print) | | First | | Middle | | Last | | 2a. DATE OF DEATH | | 2b. HOUR | |
| (LOUIE) | | T. | | McDADE | | February | | Month 9 Day 1968 | | 9:50pm | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Male | | White | | December 28, 1920 | | 47 YRS. | | MONTHS DAYS | | HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Maryland | | U.S. | | | | Baltimore | | Md | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) | | 2a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Towson | | St. Joseph Hospital | | Metal Lather | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institut admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Md. | | | | Baltimore | | | | 6506 Hilltop Ave., 21206 | | | |
| 14. FATHER'S NAME First Middle Last | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | |
| John L. McDade | | | | Ethel | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT | | Address | | | | | |
| yes | | 213031964 | | Mrs Frances McDade | | same | | | | | |
| 18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Acute anemia | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF massive pulmonary hemorrhage | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| Carcinoma of right lung | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County | | State | |
| 22a. I certify that (this hospital) attended the deceased from February 9, 1968, to February 9, 1968, that (we) last saw the deceased alive on February 9, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (do not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Reynaldo Orjuela-Gomez, M. D. | | | | | | | | 22c. DATE SIGNED February 10, 1968 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | 22e. ADDRESS | | | |
| Reynaldo Orjuela-Gomez, M. D. | | | | | | | | 7620 York Road, Towson 4, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| burial | | 2-13-68 | | Meadowridge Cem. | | Dorsey Howard Md. | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | | 25a. REC'D BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE | | | |
| Leonard J. Ruck, Inc. Baltimore, Md. | | | | | | 13 1968 | | | | | |

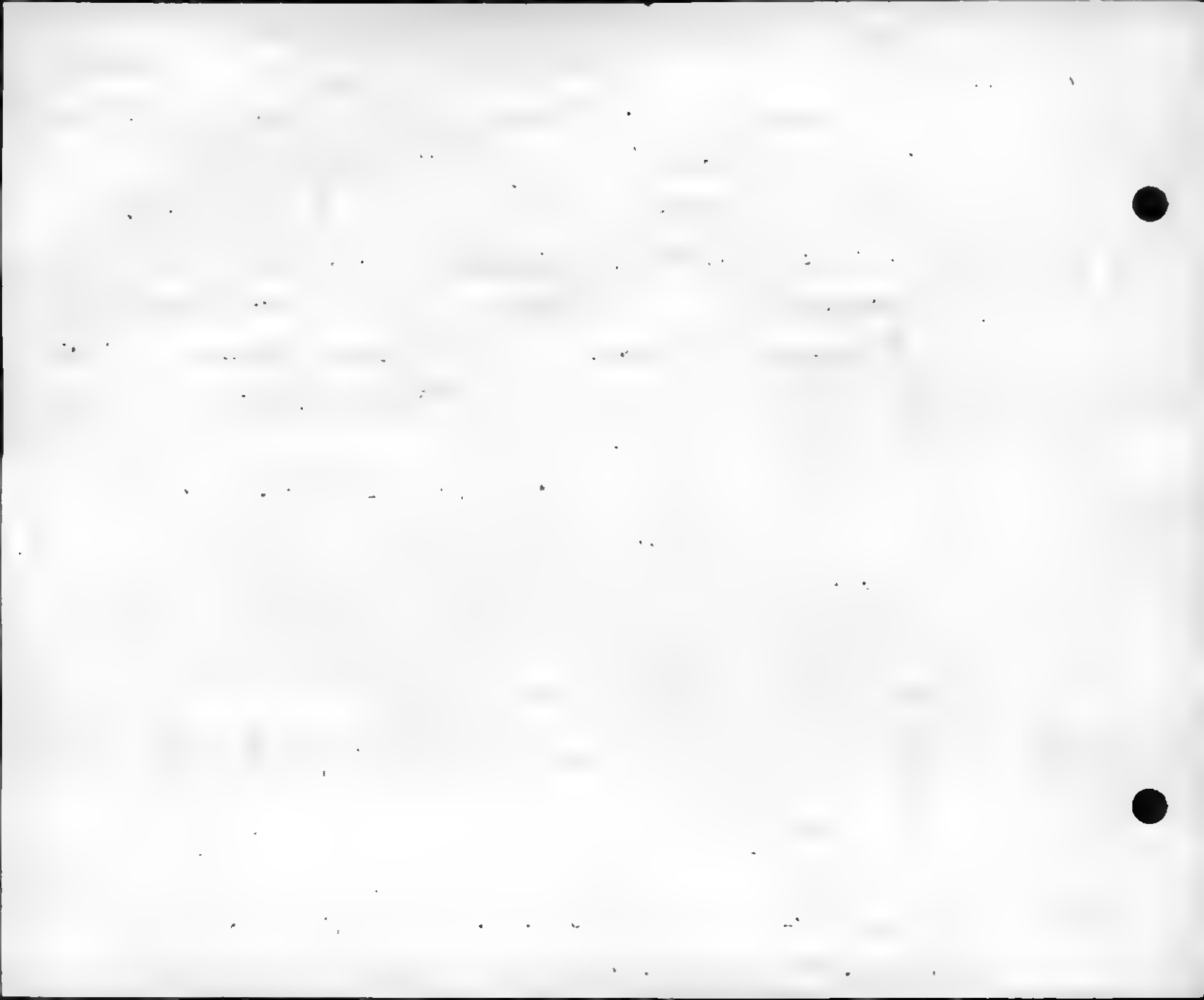
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MIDDLE | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|---|--|--|--|--|--|-----------------|--|--|--------|--|--|------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First | | | Middle | | | Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | | | | | | |
| Frances | | | McDaniel | | | | | | | | | Month 2 Day 4 Year 68 | | | 4:50 PM | | | | | | | | |
| 3 SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years lost birthday) | | | IF UNDER 1 YEAR | | | IF UNDER 24 HRS | | | | | | | | |
| Female | | | Colored | | | 12-14-10 | | | 57 YRS. | | | MONTHS DAYS HOURS MIN | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | |
| So. Carolina | | | usa | | | | | | Balto. County | | | | | | Md. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | |
| Baltimore | | | Greater Balto. Med Center | | | House wife | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER | | | | | | | | | | | |
| Maryland | | | | | | Balto. | | | | | | 1802 Thomas Ave | | | | | | | | | | | |
| 14. FATHER'S NAME | | | First | | | Middle | | | Last | | | 15. MOTHER'S MAIDEN NAME | | | First | | | Middle | | | Last | | |
| Sherman | | | Sander. | | | | | | | | | Carrie Sander | | | White | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17 INFORMANT | | | | | | | | | | | | | | | | | |
| | | | | | | Patients Chart. | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | UNKNOWN | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | |
| (b) <u>PROBABLE MYOCARDIAL INFARCTION</u> | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | |
| (c) <u>LONGSTANDING CORON-ART. DISEASE</u> | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | | | |
| <u>CHRONIC BRONCHIAL ASTHMA</u> | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) | | | | | | | | | | | | | | | | | |
| | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED <input type="checkbox"/> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION | | | Street or R.F.D. No. | | | City or Town | | | County | | | State | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-2</u> , 19 <u>68</u> , to <u>2-4</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2-3</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | | | | | |
| <u>Josefin Aguilar</u> | | | <u>2/4/68</u> | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | | |
| JANFNO C. AGULAR | | | 6701 n. CHARLES ST. | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) | | | (County) (State) | | | | | | | | | | | |
| Burial | | | 2-8-68 | | | Arbutus Me. Pk. | | | Baltimore, Maryland | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | |
| Arlington S. Phillips | | | 1727 N. Monroe Street | | | FEB 13 1968 | | | <u>Charles J. J...</u> | | | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

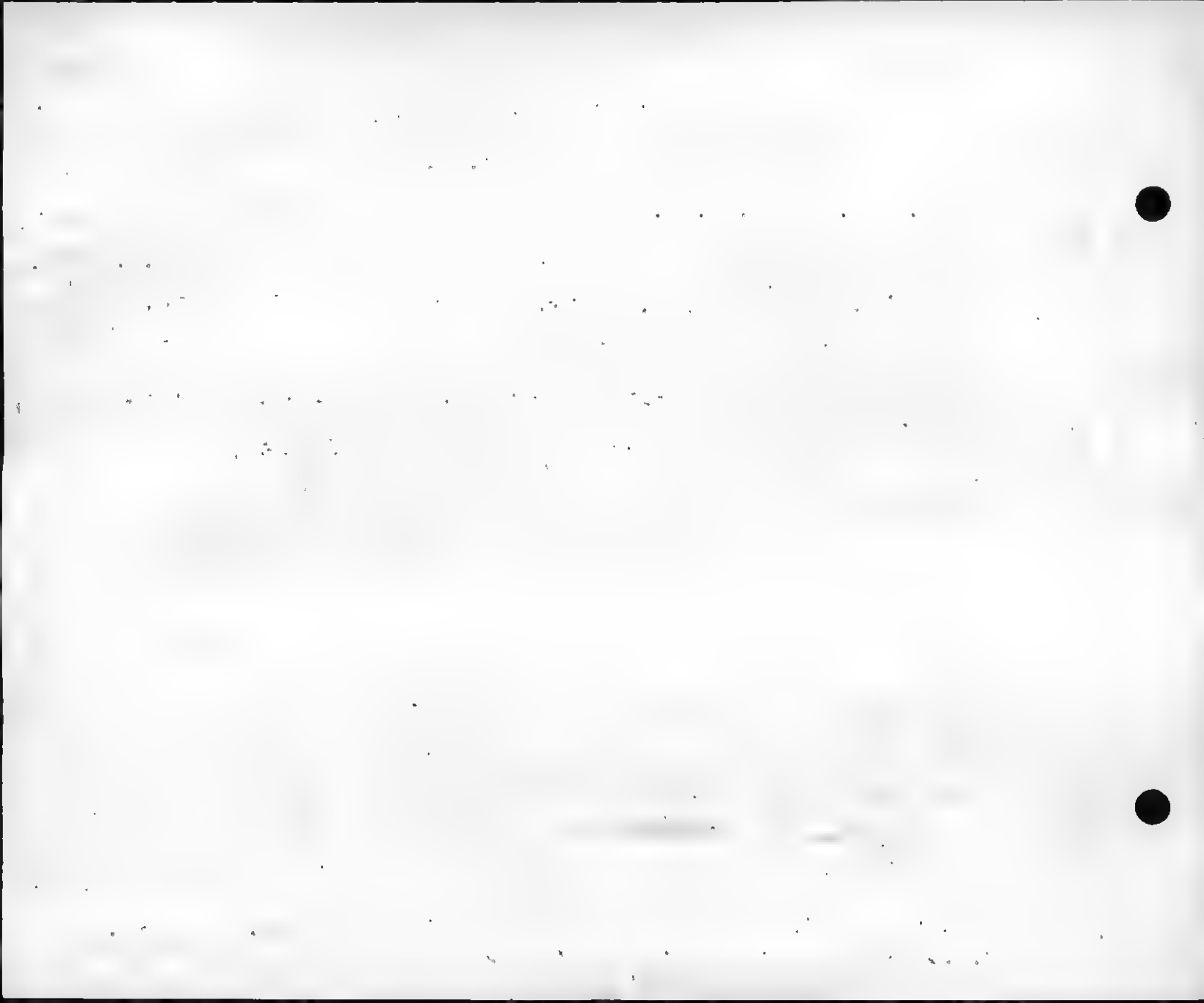
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|---|---|-------------------------------|--|--|
| 1. DECEASED-NAME
(Type or print) | | First
JOHN | | Middle
WILLIAM | | Last
McGRAIN, SR. | | 2a. DATE OF DEATH
Month <u>2</u> Day <u>21</u> Year <u>68</u> | | | 2b. HOUR
<u>1:30</u> PM | | |
| 3 SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
Nov. 1, 1885 | | | 6 AGE (In years
last birthday)
82 YRS. | | 7. UNDER 1 YEAR
MONTHS DAYS | | 7. UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign
country)
Balto., Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Greater Balto. Med. Center | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired)
Customs Service | | | 12b. KIND OF BUSINESS OR
INDUSTRY
U.S. Gov't. | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before
admission) STATE
Md. | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Towson | | 13d. INSIDE CITY L.I.M. TS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
34 Willow Ave. | | | | | |
| 14. FATHER'S NAME | | First
John | | Middle
McGrain | | Last
McGrain | | 15. MOTHER'S MAIDEN NAME | | First
Julia | | Middle
Clooney | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) <input checked="" type="checkbox"/> No | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO
218-36-0302 | | 17. INFORMANT
John W. McGrain, Jr. | | Address
(Same) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? YES | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/21, 1968</u> , to <u>2/21, 1968</u> , that (I) (we) last
saw the deceased alive on <u>2/21, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>John E. Adams</u> | | | | | | | | DEGREE
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/21/68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
John E. Adams, M.D. | | | | | | | | 22e. ADDRESS
Greater Baltimore Medical Center | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
2/24/68 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral | | 23d. LOCATION (City or Town)
Balto. | | (County)
Md. | | (State) | | | |
| 24. FUNERAL DIRECTOR
H.W. Jenkins & Sons Co. | | | | | | | | ADDRESS
1905 York Rd.
Balto. 12, Md. | | 25a. REC'D BY REGISTRAR
DATE FEB 26 1968 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

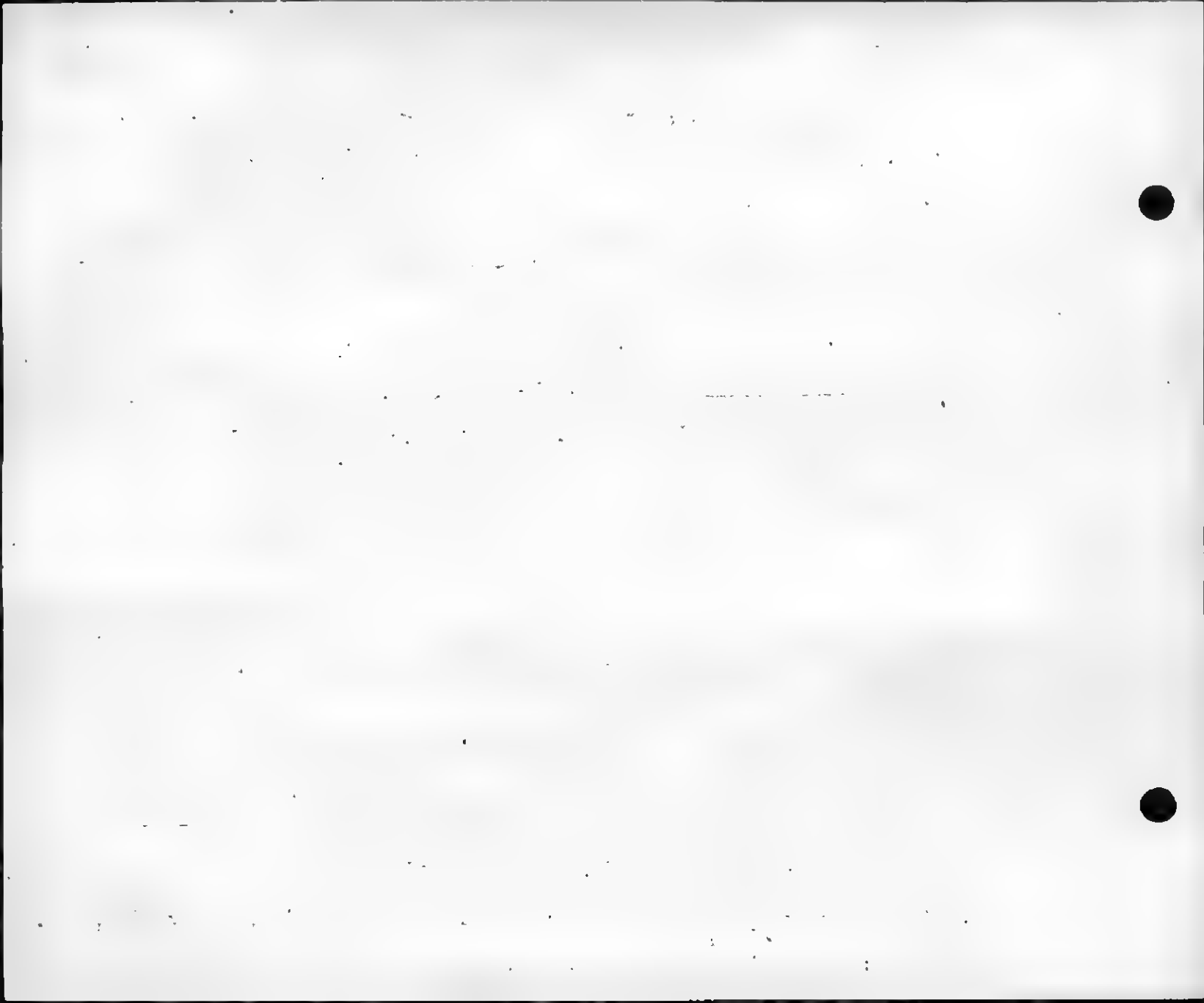
Item 18-Pt. 2 Film 397

2-14-68 ams

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|---|---|---|--|---|---|
| 1 DECEASED NAME
(Type or print) EDGAR FRANKLIN MERCER | | | 2a DATE OF DEATH
Month FEB Day 11 Year 1968 | | | 2b HOUR
1:55 P.M. | |
| 3 SEX
MALE | | 4 RACE
WHITE | | 5 DATE OF BIRTH
4-15-1894 | | 6 AGE (In years
last birthday)
73 YRS. | |
| 7a BIRTHPLACE (State or foreign
country) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH
Baltimore County Md. | |
| 10 CITY OR TOWN OF DEATH
Mount Wilson | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Mt. Wilson State Hosp. | | 12a USUAL OCCUPATION (Kind of work done
during most of working life, even if retired)
CRANE OPERATOR | | 12b KIND OF BUSINESS OR
INDUSTRY
NONE | |
| 13a USUAL RESIDENCE (Where deceased lived
admission) STATE MARYLAND | | 13b. INS DE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c CITY OR TOWN
FREDERICK | | 13e STREET AND NUMBER
240 E. 7TH STREET | |
| 14 FATHER'S NAME
First WILLIAM Middle MARLER Last MARLER | | | 15. MOTHER'S MAIDEN NAME First IDA Middle FOX Last FOX | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no or unknown) NO | | 16b. SOCIAL SECURITY NO
217-16-2216 | | 17 INFORMANT
Address Records, Mt. Wilson State Hospital | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) ISCHEMIC HEART DISEASE, M.I.
4X5X
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
411X Far advanced pulmonary tuberculosis | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? YES | |
| 21a ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory,
office building, etc.) | | 21f LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-19- , 19 67 , to 2-11- , 19 68 , that (I) (we) last
saw the deceased alive on 2-11- , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Wm. Newcomer | | | | DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED
2-11-1968 | |
| 22d. PHYSICIAN'S
NAME (Type) Wm. Newcomer, M.D. | | | | 22e. ADDRESS
Mount Wilson, Maryland | | | |
| 23a BURIAL, CREMATION,
REMOVAL (Specify) BURIAL | | 23b DATE
2-14-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Mount Olivet Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Frederick, Frederick, Md. | |
| 24 FUNERAL DIRECTOR
Robert E. Dailey & Son | | | | ADDRESS
Frederick, Md. | | 25a REC'D BY REGISTRAR
DATE 2-16-68 | |
| | | | | 25b REG STRAR'S SIGNATURE | | | |

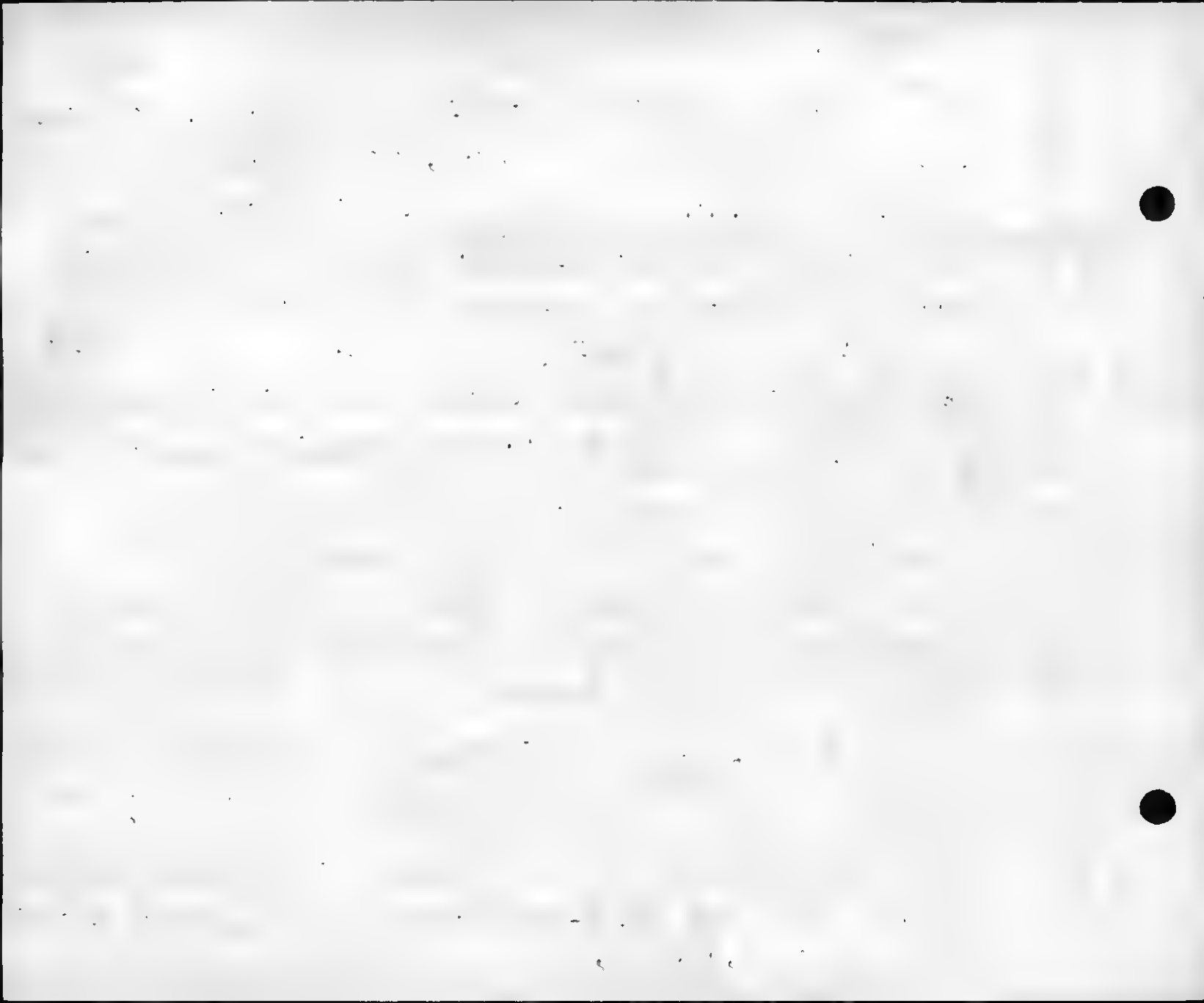


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

VR A15 (4)
30M REV. 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
|---|--|--|--|---|---------------------------------------|--|--|--|--|---|------------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED NAME
(Type or print) First Middle Last
MARVIN WINFIELD MEREDITH | | | | | | 2a. DATE OF DEATH
Month Day Year
FEBRUARY 16 1968 | | | 2b. HOUR
11:10 PM | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
JUNE 6, 1922 | | | 6. AGE (In years last birthday)
45 YRS. | | 7. UNDER 1 YEAR
MONTHS DAYS | | 8. UNDER 24 HRS
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE Md | | | | | | |
| 10. CITY OR TOWN OF DEATH
FORT HOWARD | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)
HOSPITAL VETERANS ADMINISTRATION | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
LABORER | | | 12b. KIND OF BUSINESS OR INDUSTRY
FORESTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE
MARYLAND | | | 13b. COUNTY
DORCHESTER | | 13c. CITY OR TOWN
CAMBRIDGE | | 13d. INS. OF CITY - JW TS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
RFD # 3 | | | |
| 14. FATHER'S NAME First Middle Last
MARTIN MEREDITH | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
TIVOLA RUARK | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) (If yes give war or dates of service)
YES WW II | | | | 16b. SOCIAL SECURITY NO
218 16 5038 | | 17. INFORMANT Address
CLINICAL RECORDS, VA HOSP, FT HOWARD, MD | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF ORAL CAVITY WITH METASTASIS
17-7
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 Mo | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
174X | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 1/22/68 , 19____, to 2/16/68 , 19____, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 2/16/68 , 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) not view the body after death | | | | | | | | | | | | |
| 22b. SIGNATURE
Elsa M. Goris DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | | | | | | | 22c. DATE SIGNED
2/17/68 | | | | |
| 22d. PHYSICIAN'S NAME (Type)
ELSA M. GORIS, MD | | | | | | | | 22e. ADDRESS
VA HOSPITAL, FORT HOWARD, MARYLAND | | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
Feb 20, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Spedden-Seward Cemetery | | 23d. LOCATION (City or Town) (County) (State)
RFD #3, Cambridge, Maryland | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS
LaCompte Funeral Home, Cambridge, Md | | | | | | 25a. REC'D BY REGISTRAR
FEB 23 1968 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|---|------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY BALTO MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MD b. COUNTY BALTO | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ESSEX | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ESSEX | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
327 UPPERLANDING | | d. STREET ADDRESS
327 UPPERLANDING | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
MARION E. MEYER | | 4. DATE OF DEATH
Month Day Year
FEB 20 1968 | |
| 5. SEX
F | 6. COLOR OR RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5/19/08 |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSE WIFE | | 9b. KIND OF BUSINESS OR INDUSTRY | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSE WIFE | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
MD | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
FRANCIS SELTZER | | 14. MOTHER'S MAIDEN NAME
P | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
EDWARD MEYER | | Address
ABOVE | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
DUE TO (b) Chronic Myocarditis
DUE TO (c) Rheumatic Endocarditis | | | INTERVAL BETWEEN ONSET AND DEATH
Sudden
2 yrs
5 yrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
4201 | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from July 1, 1967 to Feb 20, 1968 , that (I) (we) last saw the deceased alive on Feb 18, 1968 , and that death occurred at 2:30 M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
J. M. Baumgardner M.D. | | 22b. DATE SIGNED
2/20/68 | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS
Balto 21237 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
2/23/68 | |
| 23c. NAME OF CEMETERY OR CREMATORY
BALTO. NATL. CEM | | 23d. LOCATION (City, town or county) (State)
BALTO. MD. | |
| 24. FUNERAL DIRECTOR
J. G. CONNELLY SONS | | 25a. REC'D BY REGISTRAR
300 MACE | |
| 25b. REGISTRAR'S SIGNATURE
Charles J. [Signature] | | DATE FEB 23 1968 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

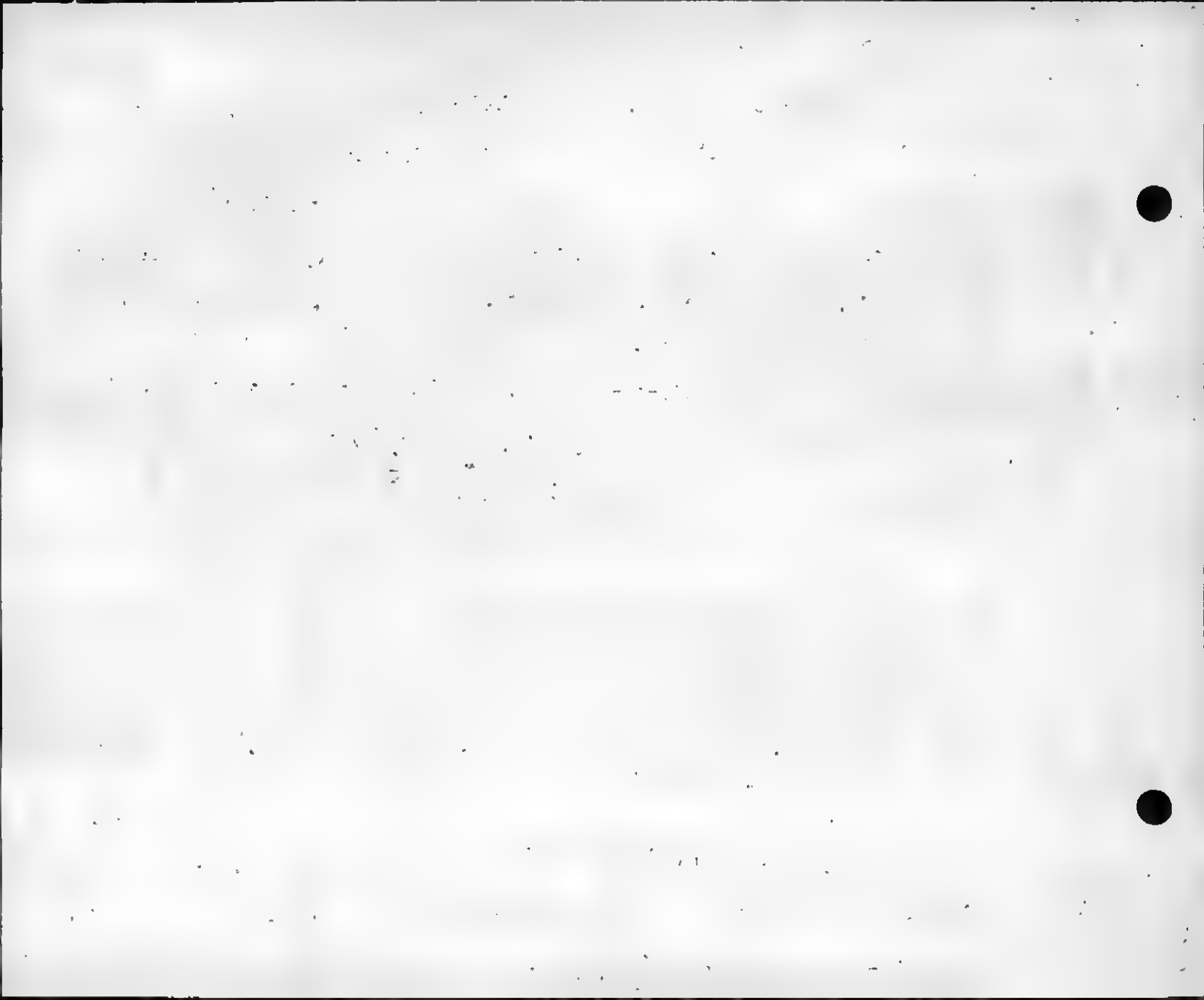


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1 DECEASED-NAME (Type or print) First Middle Last
Margaret B. Middlekauff | | | 2a. DATE OF DEATH Month Day Year
Feb. 20, 1968 | | | 2b. HOUR
M | | | |
| 3 SEX
female | | 4 RACE
white | | 5 DATE OF BIRTH
July 29, 1886 | | 6 AGE (In years last birthday)
81 YRS | | 7 UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (State or foreign country)
Maryland | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH
Baltimore | | Md | |
| 10 CITY OR TOWN OF DEATH
Stoneleigh | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Armaccost Nursing Home | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Agent | | 12b KIND OF BUSINESS OR INDUSTRY
Real Estate | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE
Md. | | 13b COUNTY
Balto. | | 13c CITY OR TOWN
Balto. | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER
308 Regester Ave. | |
| 14 FATHER'S NAME First Middle Last
William Bohn | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Theresa | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown
no | | 16b SOCIA. SECURITY NO. (If yes give war or dates of service)
319-32-0792 | | 17 INFORMANT Address
J. Carroll Power Equitable Bldg. #1 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) central vascular accident
4129
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) arteriosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4221 none | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a DATE OF OPERATION
none | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED
none | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)
White <input type="checkbox"/> Not white <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19
2/20/68 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d INJURY OCCURRED
White <input type="checkbox"/> Not white <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 2/15/68 to 2/20, 1968 , that (1) (we) last saw the deceased alive on 2/20/68 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (d.d.) did not view the body after death | | | | | | | | | |
| 22b SIGNATURE
Alan Tapper M.D. | | DEGREE
Dr. Alan Tapper | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c DATE SIGNED
2/23/68 | | | |
| 22d PHYSICIAN'S NAME (Type)
DELETED DELETED DELETED | | 22e ADDRESS
7501 York Rd. #4 | | | | | | | |
| 23a BURLIAL CREMATION, REMOVAL (Specify)
Burial | | 23b DATE
2/23/68 | | 23c NAME OF CEMETERY OR CREMATORY
Holy Redeemer | | 23d LOCATION (City or Town) (County) (State)
Baltimore, Md. | | | |
| 24 FUNERAL DIRECTOR
Mitchell-Wiedefeld Home | | ADDRESS
6500 York Rd. Balto., Md. 21212 | | 25a REC'D BY REGISTRAR
FEB 26 1968 | | 25b REGISTRAR'S SIGNATURE
[Signature] | | | |



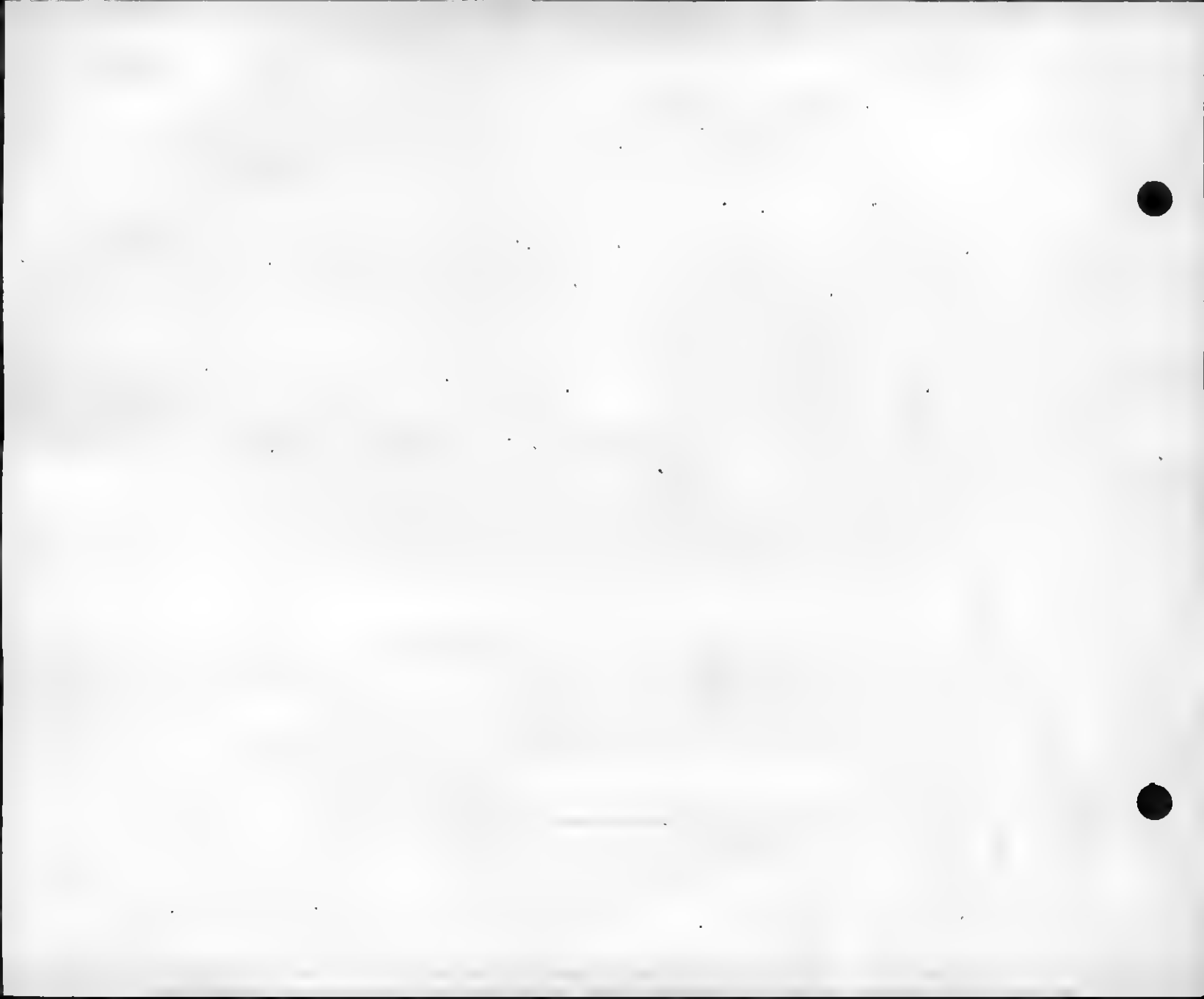
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 19. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 6 Film G396 2/20/68
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | |
|---|--------------------|---|--|---|------------------------------------|---|--|--|
| 1. DECEASED NAME (Type or Print) First Middle Last
HAZEL Jeannette MILLER | | | 2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month Day Year
Feb 20 1968 | | | 2b. HOUR OF DAY
7:15 A M | | |
| 3 SEX
F | 4 RACE
W | 5 DATE OF BIRTH
April 16, 1901 | 6 AGE in years (not birthday)
66 YRS | 7 F UNDER YEAR MONTHS DAYS
66 YRS | 8 IF UNDER 24 HRS
66 YRS | 2c. DATE PRONOUNCED DEAD Month Day Year
Feb 20 1968 | | |
| 7a. BIRTHPLACE (State or foreign country)
MD. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH
Baltimore | | |
| 10. CITY OR TOWN OF DEATH
Parkton | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
York Rd. | | | 12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)
Housewife | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE
MD. | | | 13b. COUNTY
Baltimore | | | 13c. STREET AND NUMBER
York Rd. | | |
| 14 FATHER'S NAME First Middle Last
William Uppercue | | | 15 MOTHER'S MAIDEN NAME First Middle Last
unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | | 16b. SOCIAL SECURITY NO.
220-14-7175 | | | 17 INFORMANT ADDRESS
Ellen Perry, York Rd., Parkton, MD. | | |
| B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 402x Hypertensive Heart Disease
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Instant |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or RFD No City or Town County State | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE
A. M. France | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED
2/20/68 | | |
| EXAMINER'S NAME (Type)
A. M. FRANCE | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | ADDRESS (Street, city, town or county)
PARKTON, MD | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
2/23/68 | | | 23c. NAME OF CEMETERY OR CREMATORY
White Hall, Balto., Md. | | |
| 24. FUNERAL DIRECTOR
Jacob Hartenstein, New Freedom, Pa. | | | ADDRESS | | | 25a. REC'D BY REG. STAFF
FEB 23 1968 | | |
| | | | | | | 25b. REGISTER'S SIGNATURE
Jacob Hartenstein | | |

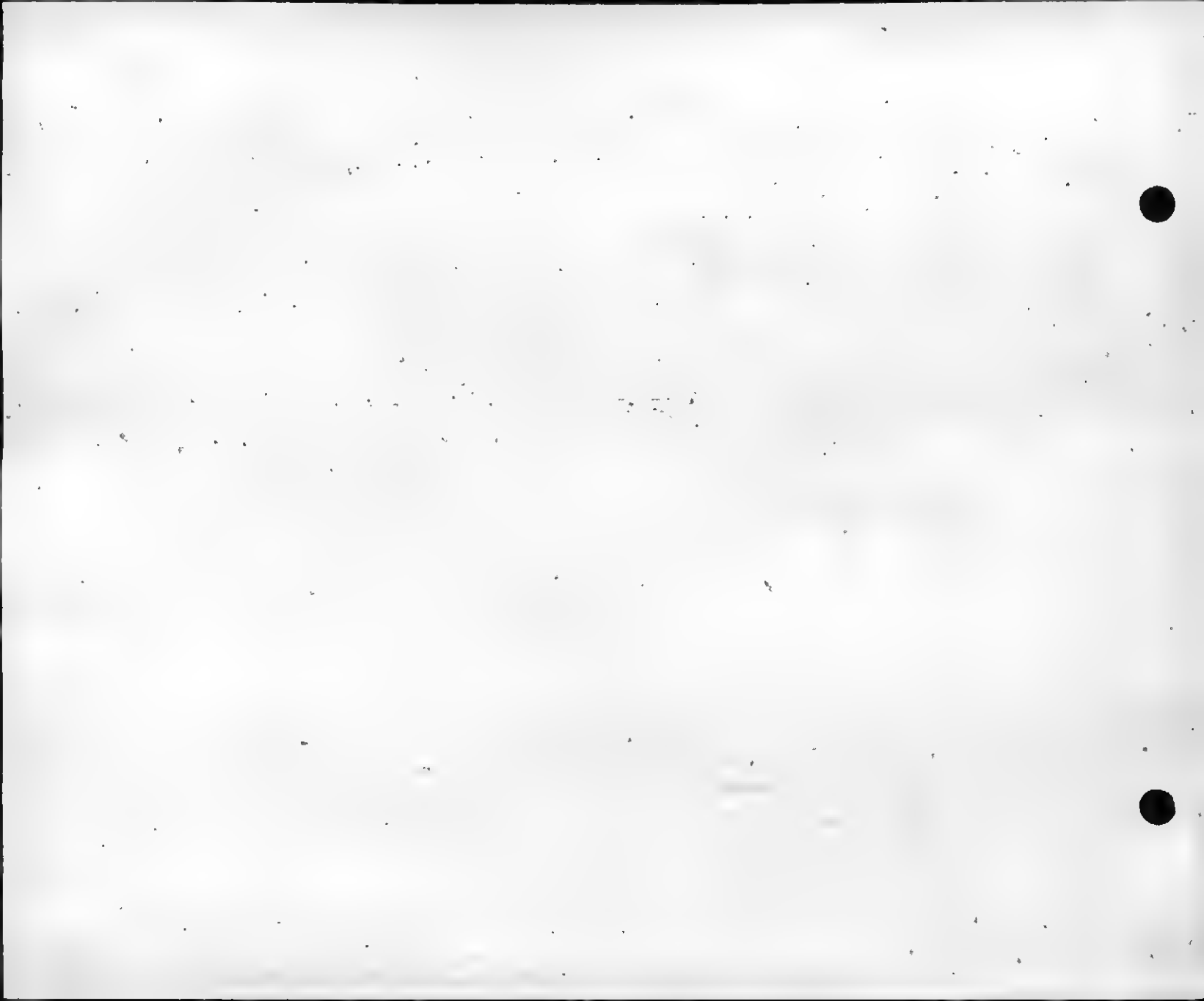


Approved by Deputy Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | |
|---|--|--|-----------------------------|---|--|---|--------------------------------|--|-------------------|--|----------------|----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1 DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a DATE OF DEATH | | | 2b HOUR | | | | |
| Henry | | | J. Miller | | | Month Day Year
February 22, 1968 | | | 6:25 P.M. | | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | | 6 AGE (In years last birthday) | | 7 UNDER 1 YEAR | | 8 UNDER 24 HRS | | |
| Male | | White | | December 26, 1890 | | | 77 YRS | | MONTHS DAYS | | HOURS MIN | | |
| 7a BIRTHPLACE (State or foreign country) | | | 7b CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 COUNTY OF DEATH | | | | |
| Maryland | | | U.S.A. | | | | | | Baltimore, Md | | | | |
| 10 CITY OR TOWN OF DEATH | | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | | 12b KIND OF BUSINESS OR INDUSTRY | |
| Hydes | | | | Ridgeview Farm | | | | Insurance | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY, M.D.? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER | | | |
| Maryland | | | | Baltimore | | Hydes | | | | Ridgeview Farm Hydes, Md | | | |
| 14 FATHER'S NAME First Middle Last | | | | 15 MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | |
| Henry Miller | | | | Teresa Deiter | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | | | 16b SOCIAL SECURITY NO | | 17 INFORMANT Address | | | | | | | |
| Yes WWI | | | | 212-10-4038 | | Mrs. Mary M. Miller Ridgeview Farm Hydes, Md | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease with Old Myocardial Infarction</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 years</u> | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | (b) <u>Old Myocardial Infarction</u> | | | |
| (c) <u>Diabetes Mellitus</u> | | | | | | | | | | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>17 years</u> | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner) | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | |
| | | | | | | | | | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County | | State | | | |
| | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 11, 1967</u> to <u>Feb 22, 1968</u> , that (I) (we) last saw the deceased alive on <u>Jan 11, 1967</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b SIGNATURE <u>Com. H. Ramsey</u> DEGREE <input type="checkbox"/> ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | | | | 22c DATE SIGNED <u>2/23/68</u> | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | | | |
| | | | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | |
| Burial | | 2/26/68 | | St. John's Long Green | | Long Green, Md. | | | | | | | |
| 24 FUNERAL DIRECTOR ADDRESS | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Wm. Cook-Brooks Towson 1050 York Rd. 21204 | | | | | | DATE FEB 26 1968 | | <u>Charles Jones</u> | | | | | |

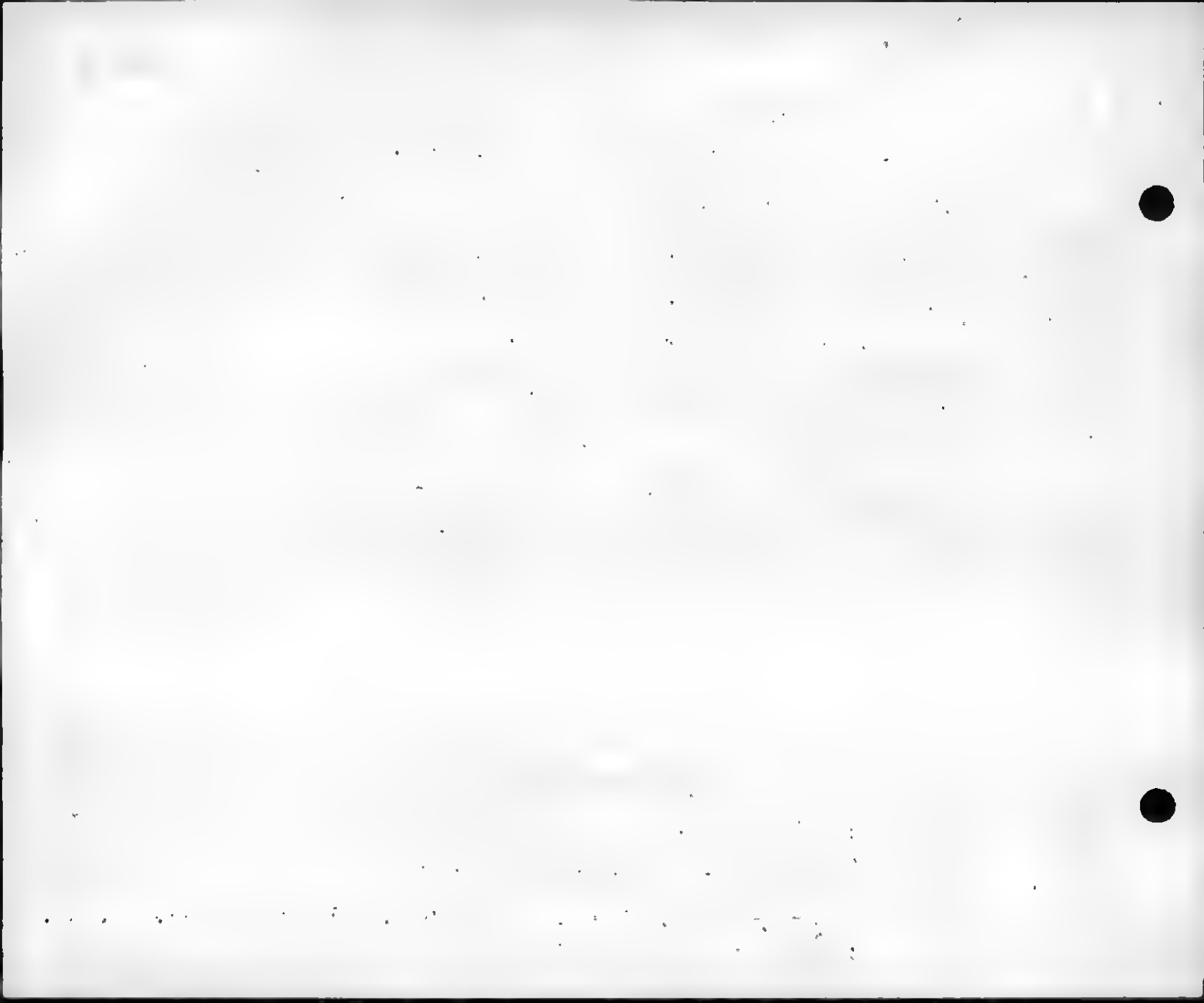


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATE

| MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|---|---|--|---|--|--|--|
| 1 DECEASED NAME
(Type or print) MARTIN LUTHER MILLER | | | 2a. DATE OF DEATH
Month FEB. Day 14 Year 1968 | | | 2b. HOUR
11.55 AM | | | |
| 3 SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
4-5-01 | | 6. AGE (In years last birthday)
66 YRS | | 7. UNDER 1 YEAR
MONTHS DAYS | |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore County, Md. | | | |
| 10. CITY OR TOWN OF DEATH
Mt. Wilson | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Mt. Wilson State Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
LABORER | | 12b. KIND OF BUSINESS OR INDUSTRY
Contractor | |
| 13a. USUAL RESIDENCE (Where deceased lived, if admission) STATE
MARYLAND | | 13b. COUNTY
FREDERICK | | 13c. CITY OR TOWN
THURMONT | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
 | |
| 14. FATHER'S NAME First Middle Last
CHARLES MILLER | | | 15. MOTHER'S MAIDEN NAME First Middle Last
UNKNOWN | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) NO (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO
NONE | | 17. INFORMANT Address
Records, Mt. Wilson State Hospital | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) COR PULMONALE
DUE TO, OR AS A CONSEQUENCE OF
(b) OBSTRUCTIVE AIRWAY DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) PULM T.B. FAR ADVANCED ACTIVE
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-5- , 19 67 , to 2-14- , 19 68 , that (I) (we) last saw the deceased alive on 2-14- , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
W. Newcomer | | | DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (Type)
William Newcomer, M.D. | | | 22e. ADDRESS
Mount Wilson, Maryland | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
2-18-68 | | 23c. NAME OF CEMETERY OR CREMATORY
United Brethren Cem. | | 23d. LOCATION (City or Town) (County) (State)
Thurmont Fred. Co. Md. | | | |
| 24. FUNERAL DIRECTOR
Raymond E. Ensign | | 24b. ADDRESS
215/16 | | 25a. REC'D BY REG STRAR
DATE FEB 20 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles J. Jones | | | |



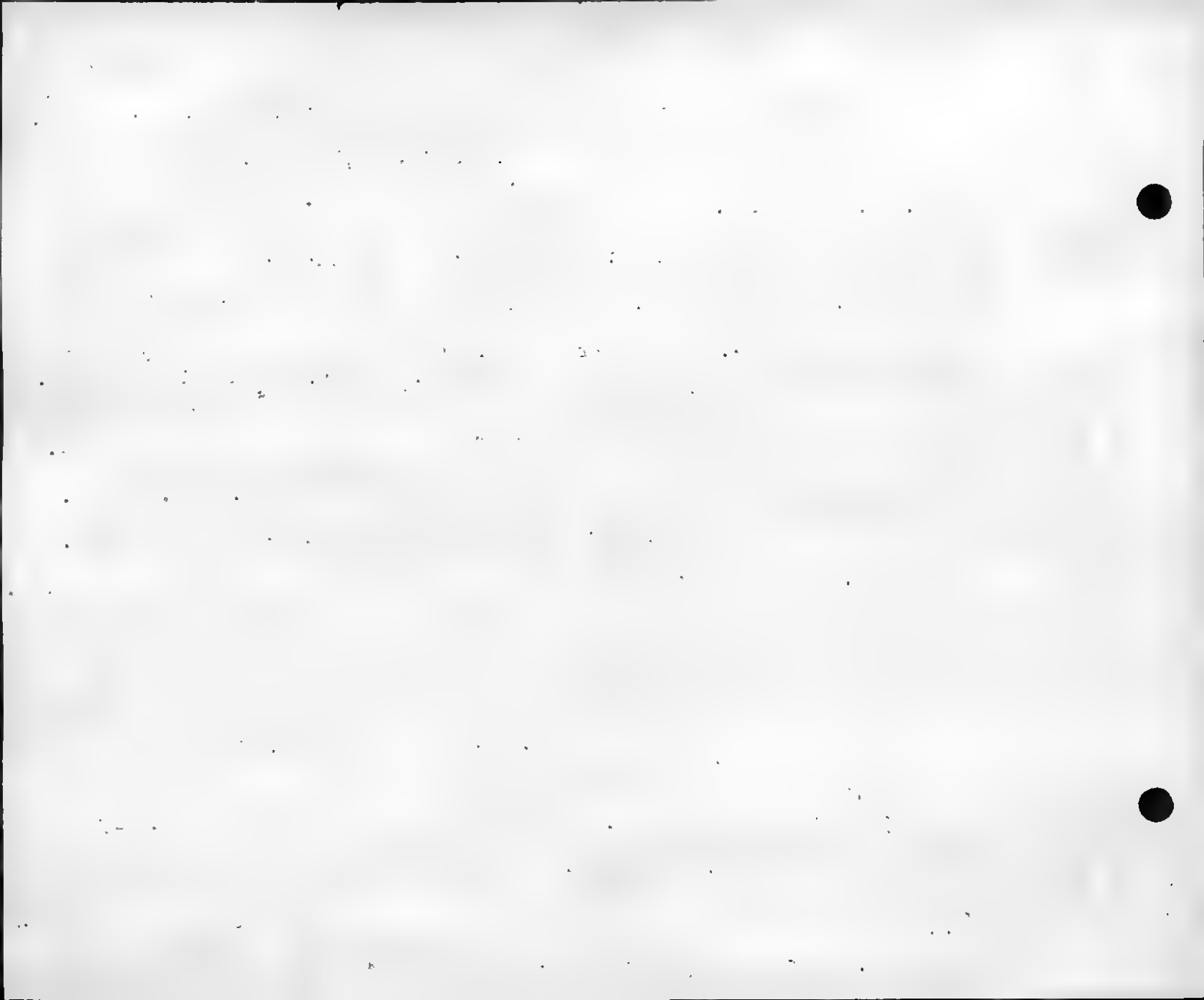
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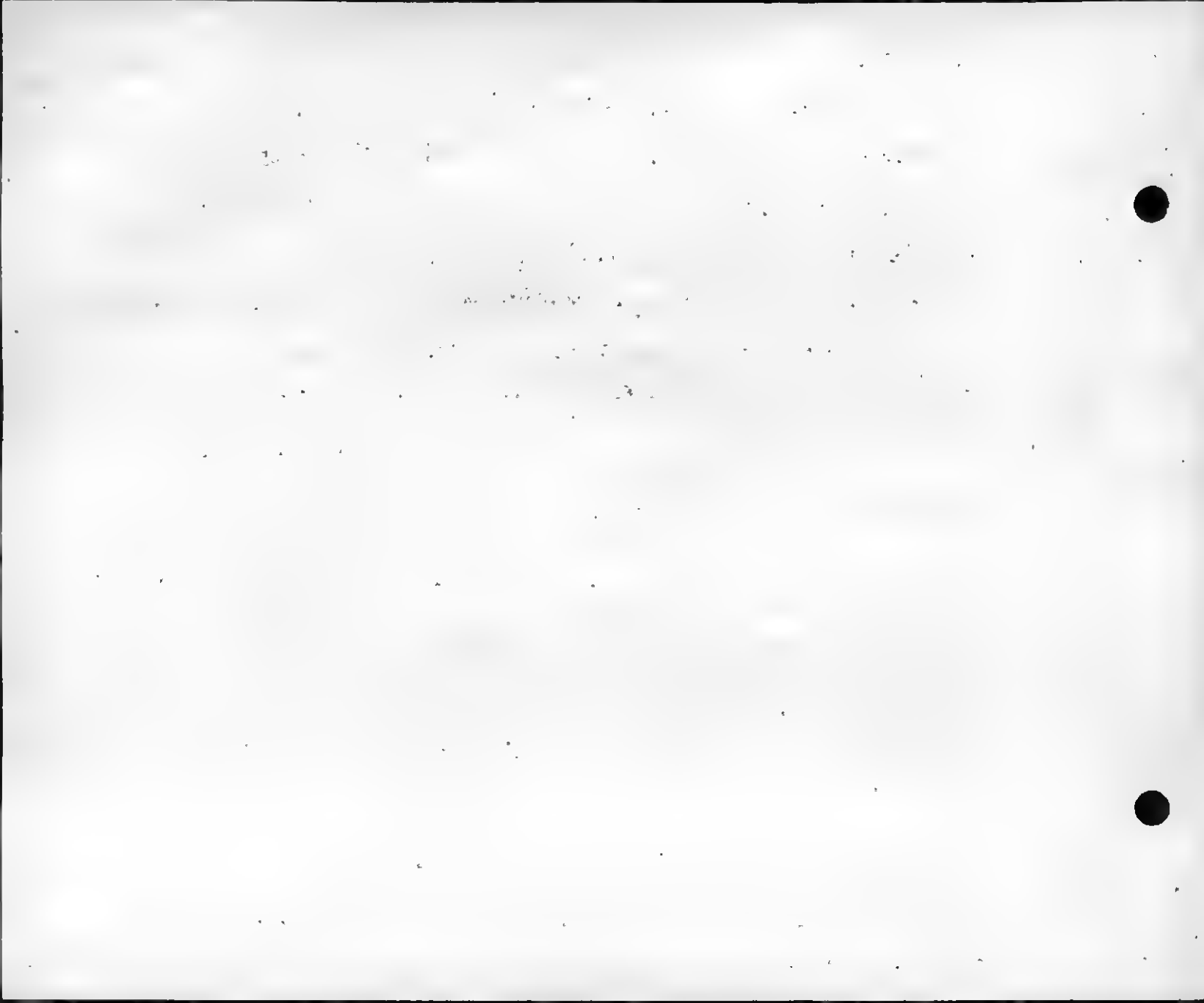
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the papers. Pages 1 and 2 should be filed in by the funeral director, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH | | | | | | | | | | | | | |
|---|--|------------------|--|---|--|---|---|--|---|---|---------------------------------|--|--|
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR
4:15 PM | | | | |
| Roland | | | Thomas | | | Miller | | | February 20, 1968 | | | | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH / 1891
April 10, 1889 | | | 6. AGE (In years last birthday)
76 yrs | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 8. IF UNDER 24 HRS
HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country)
W. Va. | | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Baltimore Md | | | | |
| 10. CITY OR TOWN OF DEATH
Catonsville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
SPRING GROVE STATE HOSP. | | | 12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)
electrician | | | 12b. KIND OF BUSINESS OR INDUSTRY
retired | | | | |
| 13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE
Md. | | | 13b. COUNTY
Balto. | | | 13c. CITY OR TOWN
Lansdowne | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER
408 First Avenue | |
| 14. FATHER'S NAME
First Middle Last
Daniel W. Miller | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Anna Hockenberry | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No | | | 16b. SOCIAL SECURITY NO
216-05-2413 | | | 17. INFORMANT
Mrs. Clara E. Miller 408 First Ave.
Records: SPRING GROVE STATE HOSPITAL | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic atrial fibrillation
(c) Arteriosclerotic Cardiovascular Disease 7 yrs.
DUE TO, OR AS A CONSEQUENCE OF (d) Arteriosclerosis, Generalized, Senile 7 yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS (CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a))
Benign Prostatic Hypertrophy with chronic cystitis & urinary reten. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 min. | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from March 25, 1961, to Feb. 20, 1968, that (X) (we) lost saw the deceased alive on Feb. 20, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE

Anthony J. Young, M.D. | | | | | | | | | 22c. DATE SIGNED
2-20-68 | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Anthony J. Young, M.D. | | | | | | | | | 22e. ADDRESS
SPRING GROVE STATE HOSPITAL
Baltimore, Maryland 21228 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
2/22/68 | | | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Park | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Md. | | | | |
| 24. FUNERAL DIRECTOR
Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | | | | 25a. REC'D BY REGISTRAR
DATE FEB 23 1968 | | | 25b. REGISTRAR'S SIGNATURE
 | | | | |





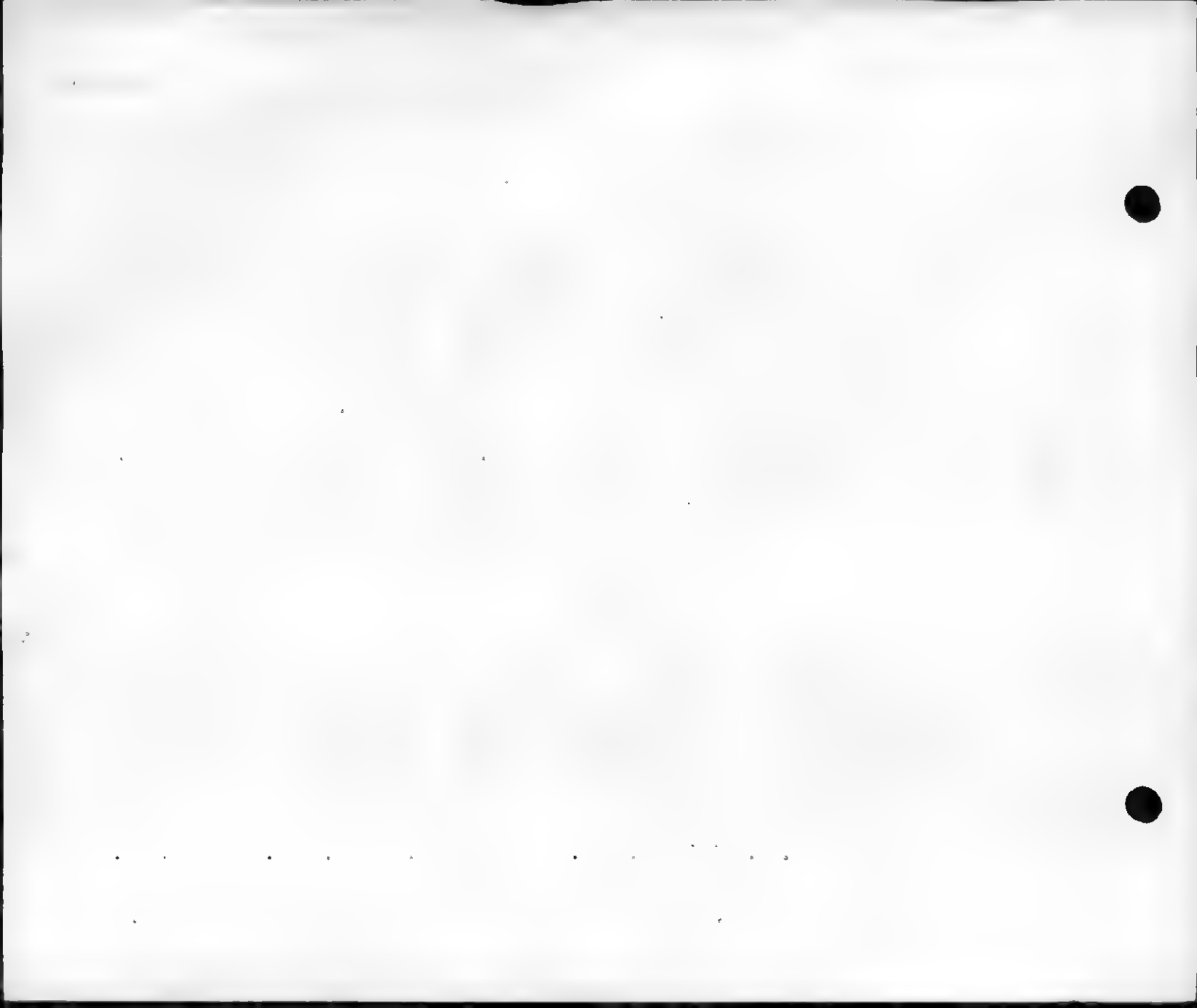
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|--|---|--|
| 1 PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Towson 21204</u> | | c. LENGTH OF STAY IN 1b
<u>2 1/2 yrs.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>917 Dunellen Drive</u> | | d. STREET ADDRESS
<u>917 Dunellen Drive</u> | |
| 3 NAME OF DECEASED (Type or print)
First <u>Alice</u> Middle <u>Paula</u> Last <u>Mitchell</u> | | 4 DATE OF DEATH
Month <u>February</u> Day <u>6</u> Year <u>1968</u> | |
| 5 SEX
<u>Female</u> | 6 COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH
<u>March 11, 1972</u> |
| 9 AGE (In years last birthday)
<u>95</u> yrs | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | IF UNDER 24 HRS
Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>at home</u> | |
| 11 BIRTHPLACE (County & State, or foreign country)
<u>Pennsylvania</u> | | 12 CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Christian Stricker</u> | | 14. MOTHER'S MAIDEN NAME
<u>Emily C. Orr</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes; no, or unknown) (If yes give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>one</u> | |
| 17. INFORMANT
<u>Mrs. Helen Sprung, 917 Dunellen Dr., Towson</u> | | Address | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ARTERIO-SCLEROTIC HEART DISEASE</u>
DUE TO (b) <u>GENERALIZED ARTERIO-SCLEROSIS</u>
DUE TO (c) <u> </u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19 WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>MAY 1967</u> to <u>FEB 6, 1968</u> , that (I) (we) last saw the deceased alive on <u>FEB 4, 1968</u> , and that death occurred on <u>FEB 6 AM</u> , from causes on and on the date stated above. | | | |
| 22a. SIGNATURE
<u>T. C. Siwinski</u> | | 22b. DATE SIGNED
<u>FEB 6 1968</u> | 22c. ADDRESS
<u>206 W. Penna. Ave., Towson, Md. 21204</u> |
| 22c. PHYSICIAN'S NAME (Type)
<u>T. C. Siwinski, M.D.</u> | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or town) (County) (State) |
| <u>burial</u> | <u>Feb. 10, 1968</u> | <u>Washington, D.C.</u> | <u>Washington, D.C.</u> |
| 24. FUNERAL DIRECTOR
<u>John W. Sons, Towson, Md.</u> | | 25a. REC'D BY REG. STRAR
<u>FEB 8 1968</u> | 25b. REGISTRAR'S SIGNATURE
<u>Charles J. ...</u> |



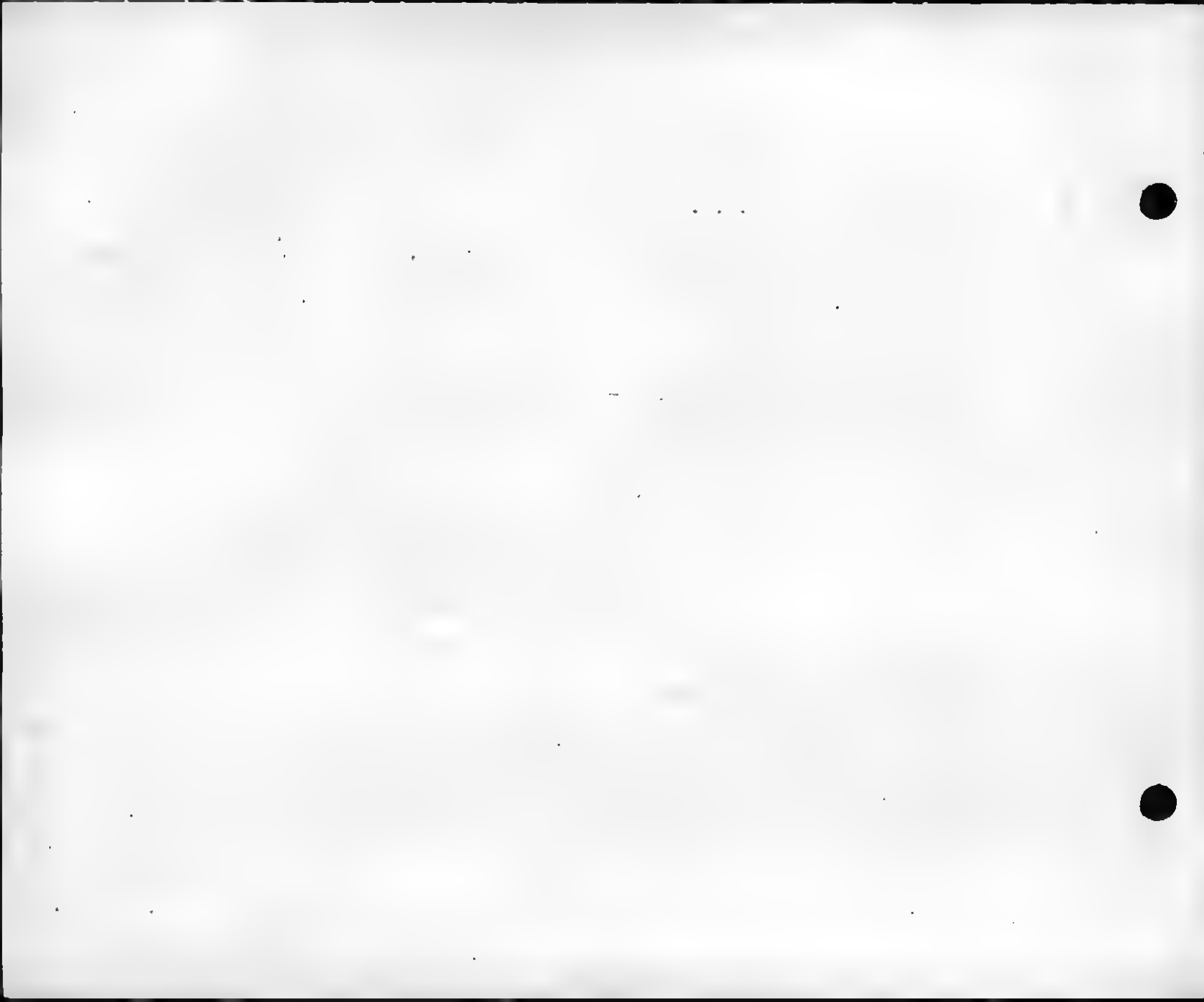
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. Five pages (and 2 with the State Department of Health) prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

2283
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #6 File # 3391 3/1/68
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | |
|--|---------------|---|--|--|---|--|--|--|--------------------|
| 1 DECEASED NAME
(Type or Print) First Middle Last
Carl Mohr | | | 2a DATE KNOWN OF EST-
DEATH MATED <input type="checkbox"/> Month Day Year
2 10 19 68 | | | 2b HOUR
6:20 | | | |
| 3 SEX
Male | 4 RACE
Cau | 5 DATE OF BIRTH
6-22-1 59 | 6 AGE (In years last birthday)
73 79 YRS | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | IF UNDER 24 HRS
HOURS MIN | | 2c DATE PRONOUNCED DEAD
Month 2 Day 10 Year 19 68 | 2d HOUR
1:35 PM |
| 7a BIRTHPLACE (State or foreign country)
Baltimore | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md | | | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
8801 Mayflower Rd. | | | 12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)
Self-employed | | 12b KIND OF BUSINESS OR INDUSTRY
Storekeeper | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE
Md. | | 13b COUNTY
Baltimore | | 13c CITY OR TOWN
Rossville | | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER
8801 Mayflower Road 06 | |
| 14 FATHER'S NAME First Middle Last
Charles Mohr | | | 15 MOTHER'S MAIDEN NAME First Middle Last
Elizabeth Kern | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | 16b SOCIAL SECURITY NO
(If yes give war or dates of service)
216-DE-5261A | | 17. INFORMANT
May Reinhardt | | | ADDRESS
8801 Mayflower Road 06 | | |
| 18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4121 H-S-C-V-DISEASE
DUE TO, OR AS A CONSEQUENCE OF SENILITY
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)
4 | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
None | | | | 20 AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M.
19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f LOCATION Street or R.F.D. No City or Town County State | | | | |
| 22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE
MELVIN B. DAVIS M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b DATE SIGNED
2/10/68 | | | |
| EXAMINER'S NAME (Type) | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | ADDRESS (Street, city, town, or county)
6800 BOWENINGTON RD DUNDALK MARYLAND | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL. (Specify)
BURIAL | | 23b DATE
2-13-1968 | | 23c NAME OF CEMETERY OR CREMATORY
Aion Cemetery | | | 23d LOCATION (City or Town) (County) (State)
Baltimore Co. Md. | | |
| 24 FUNERAL DIRECTOR
Massachusetts Funeral Home 7401 Belair Road | | | | ADDRESS
36 | | 25a REC'D BY REGISTRAR
DATE FEB 13 1968 | | 25b REGISTRAR'S SIGNATURE | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, not less than 48 hours after death.

VR A15 (4)
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | |
|---|---|---|--|---|---|
| 1. DECEASED NAME
(Type or print) JOHN T. MORTON | | | 2a. DATE OF DEATH
Month 2- Day 18- Year 68 | | 2b. HOUR
M |
| 3 SEX
Male | 4. RACE
Negro | 5. DATE OF BIRTH
4-7-1892 | | 6. AGE (In years last birthday)
75 YRS | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)
Charlotte, Va. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
Dundalk | | 10. CITY OR TOWN OF DEATH
Sollors Point |
| 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
2708 Delk Court | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Miner | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD. | | 13b. COUNTY
Balto. | 13c. INS-OR CITY LINE? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER
1714 Laurens Street | |
| 14. FATHER'S NAME First Middle Last
Unk. | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Unk. | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, na, or unknown | | 16b. SOCIAL SECURITY NO
232-14-8310 | 17. INFORMANT Address
Mr. Alton W. Lewis 2708 Delk Court | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Carcinoma of Lung
1621 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | |
| 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home farm street, factory, office building, etc) | | 21f. LOCATION Street or R.F.D. No City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/2/68 , 19 68 , to 2/18 , 19 68 , that (I) (we) last saw the deceased alive on 2/18 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Theo C Patterson | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
2/19/68 | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
2-24-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Memorial Pk. | |
| 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | 24. FUNERAL DIRECTOR
MORTON & DYETT F.H. 1701 Laurens St. | | | |
| 25a. RECD BY REGISTRAR
DATE FEB 23 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | |
|--|--|--|---|---|--|--|--|--|--|--|--|---|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last
Louis MRAZIER MUTH | | | 2a. DATE OF DEATH
Month February Day 11 Year 1968 | | | 2b. HOUR M | | | | | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
JULY 12, 1885 | | 6. AGE (In years last birthday)
82 YRS. | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | IF UNDER 24 HRS
HOURS 0 MIN 0 | | | | |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE Md | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Shady Nook Home - CATONSVILLE | | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)
1003 N. Rolling Rd. PASTAL CLERK | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
U.S. Gov't | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE
Maryland | | | 13b. COUNTY
BALTIMORE | | | 13c. CITY OR TOWN
BALTIMORE | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
2613 WILKENS AVE | | |
| 14. FATHER'S NAME First Middle Last
Louis MUTH | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
AMELIA | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO.
216-24-6062 | | | | 17. INFORMANT Address
Pauline MUTH 2613 WILKENS AVE. | | | | | | |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4120 Acute myocardial failure
DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.V. R. disease
DUE TO, OR AS A CONSEQUENCE OF (c) ? | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 wks | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Pneumonia - Urinary tract infection | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/15 , 19 68 , to 2/11 , 19 68 , that (I) (we) last saw the deceased alive on 2/11 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE
D.C. MacLaughlin | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED
2/12/68 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
D.C. MacLaughlin | | | | 22e. ADDRESS
303 N. Rolling Rd | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
2-14-68 | | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE Md | | | | | | | | |
| 24. FUNERAL DIRECTOR
Francis H. Miller 2101 Frederick Ave | | | | 25a. REC'D BY REGISTRAR
DATE FEB 13 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | |

W.L.L.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and 2. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|---|--|--|--|---|--|--------------------------|--|-------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1 DECEASED NAME (Type or print) | | First | | Middle | | Last | | 2a DATE OF DEATH | | 2b HOUR | |
| Dora | | A. | | Naylor | | | | February 1958 | | M | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Female | | White | | June 13, 1871 | | 98 YRS. | | MONTHS | | DAYS | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Balto. Co. Md. | | USA | | | | Baltimore | | | | Md | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | |
| Reisterstown | | 200 Main Street | | Housewife | | | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution admission) | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY - WITS? | | 13e STREET AND NUMBER | | | |
| Md. | | Balto. | | Reisterstown | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 200 Main Street | | | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | First Middle Last | |
| William | | Allman | | | | | | Martha | | McClure | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO | | 17 INFORMANT | | Address | | | | | |
| No | | None | | Mrs. Mary Johnson | | Reisterstown, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Myocardial infarction - 5 yrs</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic atherosclerosis</u> | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Active infection of respiratory tract</u> | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC) | | 21f LOCATION | | Street or R.F.D. No | | City or Town | | County State | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-1-</u> , 19 <u>30</u> , to <u>2-15</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | | | | |
| 22b SIGNATURE | | 22c. DATE SIGNED | | DEGREE | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | |
| James C. Saffell | | 2-16-68 | | | | | | | | | |
| 22d PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | | | |
| James C. Saffell | | Reisterstown, Md | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) | | (County) | | (State) | |
| Burial | | 2/19/68 | | All Saints | | Reisterstown, Md. | | | | | |
| 24 FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REC'D BY REGISTRAR | | | | | |
| J. F. Eline & Sons | | Reisterstown, Md. | | FEB 19 1968 | | | | | | | |

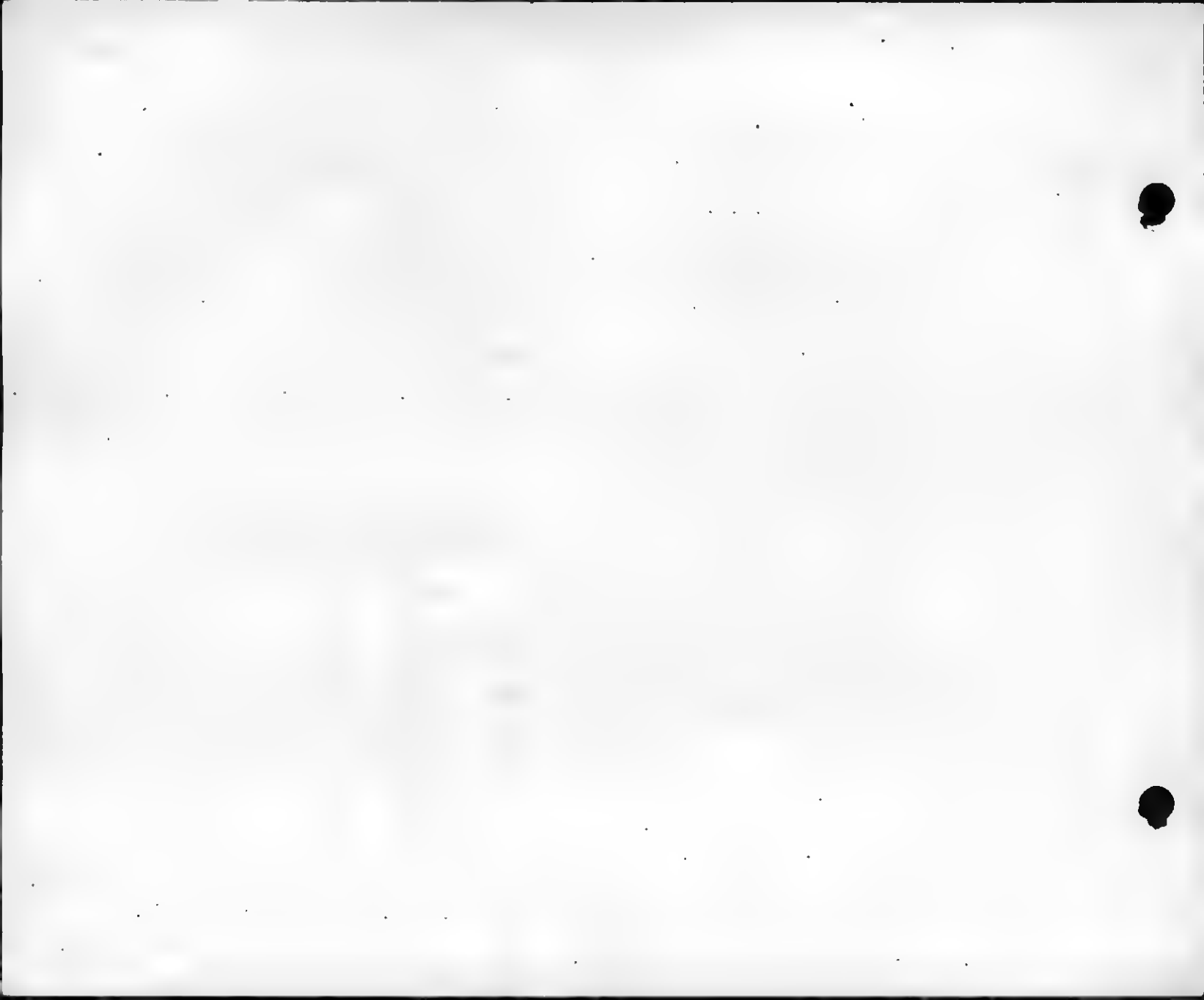


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|--------|-----------------------------|---|--|----------------|---|--|--|---|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1 DECEASED NAME
(Type or Print) | | | First Middle Last | | | 2a DATE KNOWN OF DEATH | | | 2b HOUR | | |
| MARY K. NAYLOR | | | | | | Month Day Year | | | 2b HOUR | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (in years last birthday) | 7 UNDER 1 YEAR | 8 UNDER 24 HRS | 2c DATE PRONOUNCED DEAD | | | 2d HOUR | | |
| Female | White | March 16, 1934 | 33 YRS | MONTHS DAYS | HOURS MIN | Month Day Year | | | 2d HOUR | | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | 10 | | |
| Maryland | | U.S.A. | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Baltimore | | | Md | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| Parkton | | | Sampson Rd. | | | Housewife | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if admission) STATE | | | 13b COUNTY | | | 13c CITY OR TOWN | | | 13d INSIDE CITY LIMITS? | | |
| Maryland | | | Baltimore | | | Parkton | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14 FATHER'S NAME | | | 15 MOTHER'S MAIDEN NAME | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b SOCIAL SECURITY NO | | |
| John T. Redman | | | Blanche Bosley | | | No | | | None | | |
| 17 INFORMANT | | | 18 ADDRESS | | | 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | |
| Mr. Louis W. Naylor | | | Sampson Rd. Parkton, Md. | | | 4 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | |
| PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Embolism</u> | | | 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | |
| 1107 DUE TO, OR AS A CONSEQUENCE OF | | | 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | |
| (c) DUE TO, OR AS A CONSEQUENCE OF | | | 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 4 | | | | | | | | | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> | | | 21b TIME OF INJURY Month, Day, Year | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18) | | | 20. AUTOPSY? | | |
| CAUSE OF DEATH | | | 19 | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f LOCATION Street or RFD No | | | City or Town | | |
| | | | | | | | | | County | | |
| | | | | | | | | | State | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion an death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER | | | 22b DATE SIGNED | | | | | |
| EXAMINER'S NAME (Type) | | | ASSISTANT MEDICAL EXAMINER | | | 22b DATE SIGNED | | | | | |
| A. M. FRANCE | | | DEPUTY MEDICAL EXAMINER | | | 22b DATE SIGNED | | | | | |
| | | | ADDRESS (Street, city, town, or county) | | | 22b DATE SIGNED | | | | | |
| | | | | | | 22b DATE SIGNED | | | | | |
| 23a BURIAL: CREMATION, REMOVAL (Specify) | | | 23b DATE | | | 23c NAME OF CEMETERY OR CREMATORY | | | 23d LOCATION (City or Town) (County) (State) | | |
| Burial | | | 3/1/68 | | | Dulaney Valley Mem. Cem. | | | Cockeysville, Md. | | |
| 24 FUNERAL DIRECTOR | | | ADDRESS | | | 25a RECD BY REGISTRAR | | | 25b REGISTRAR'S SIGNATURE | | |
| Wm. Cook-Brooks Towson 1050 York Rd. 21204 | | | | | | DATE FEB 29 1968 | | | F. J. J. J. | | |



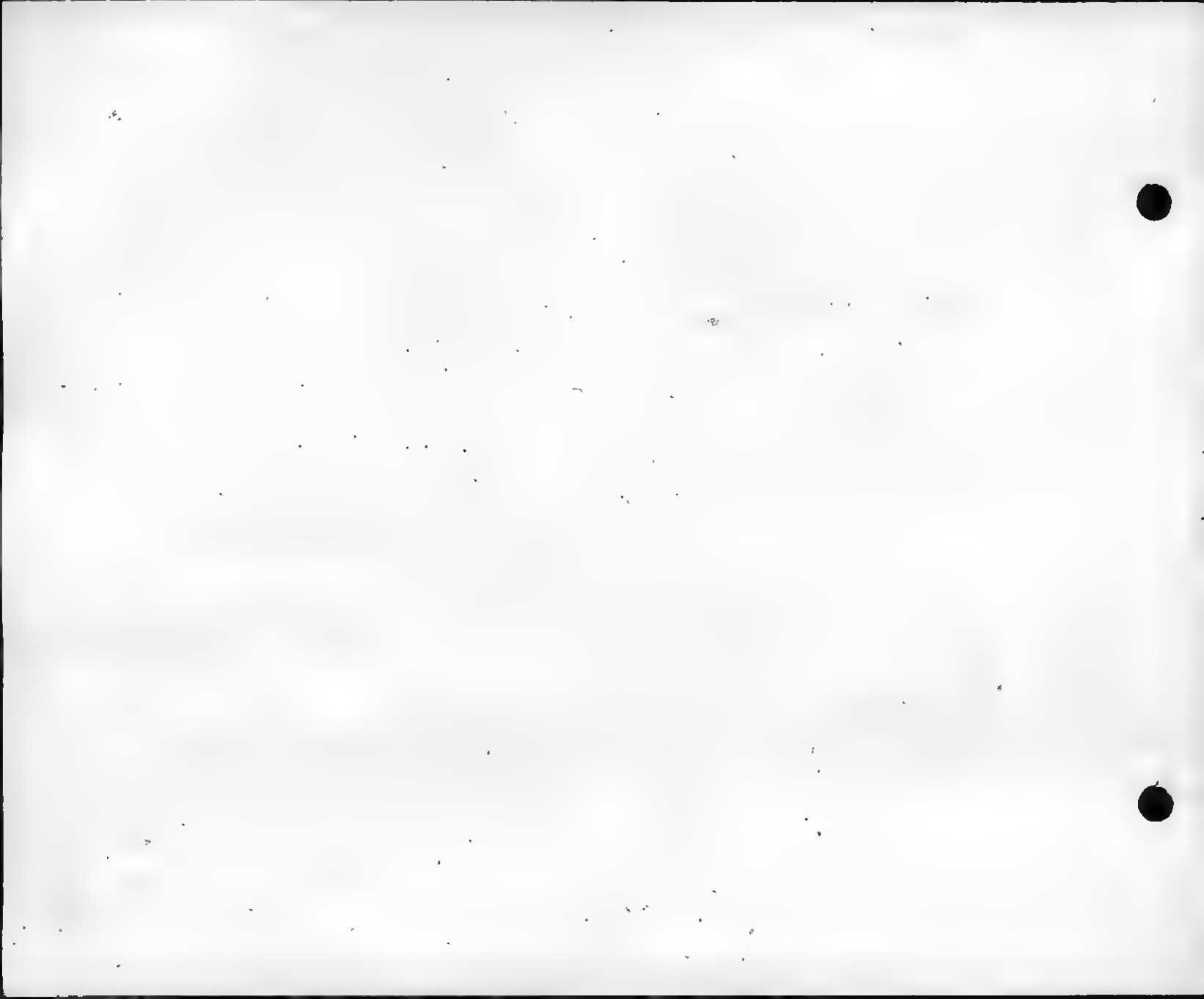
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VR A15 (4)
30M REV 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | |
|---|--|---------|--|------------------|--|--|---------------------------------|---|--|--------------------------------|---------------------------|------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
| 1. DECEASED NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | | | |
| Mary Elizabeth Neumann | | | | | | February 6 1968 | | | 3:45 AM | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | | | |
| Female | | White | | July 4th 1886 | | | 81 YRS | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | |
| State | | | U S A | | | | | | Baltimore County | | | Md | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Catoonsville Md | | | Forest Haven 315 Indiana Ave | | | | | | | | | | | |
| 13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER | | |
| MD | | | --- | | | Baltimore | | | YES | | | 314 Lorraine Ave | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| William Benton | | | Mary Jubb | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO | | | 17. INFORMANT | | | Address | | | | | |
| Yes, no, or unknown | | | 215-01-7776 | | | Forest Haven Nursing Home | | | Above | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>410.9</u> <u>MALFORMED - PERFORATION OF COLON - ULCER</u> | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF <u>DISINFECTION</u> | | | | | | | | | | | | | | |
| (b) <u>PERFORATION OF COLON - ULCER</u> | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF <u>PERFORATION OF COLON - ULCER</u> | | | | | | | | | | | | | | |
| (c) <u>PERFORATION OF COLON - ULCER</u> | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | | | |
| | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/8</u> , 19 <u>64</u> , to <u>2-6</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>7/8</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Dr. John Shaw</u> | | | | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>2/6/68</u> | | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>Dr. John Shaw</u> | | | | | | | | 22e. ADDRESS <u>5800 Edmondson Ave</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | | 2-10-68 | | | Parkwood | | | Baltimore Md | | | | | |
| 24. FUNERAL DIRECTOR <u>Thelma A. Hoffman</u> | | | | | | ADDRESS <u>3218 Hudson St</u> | | | | | | | | |
| 25a. REC'D BY REGISTRAR <u>DATE FEB 13 1968</u> | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | |

MEDICAL CERTIFICATION

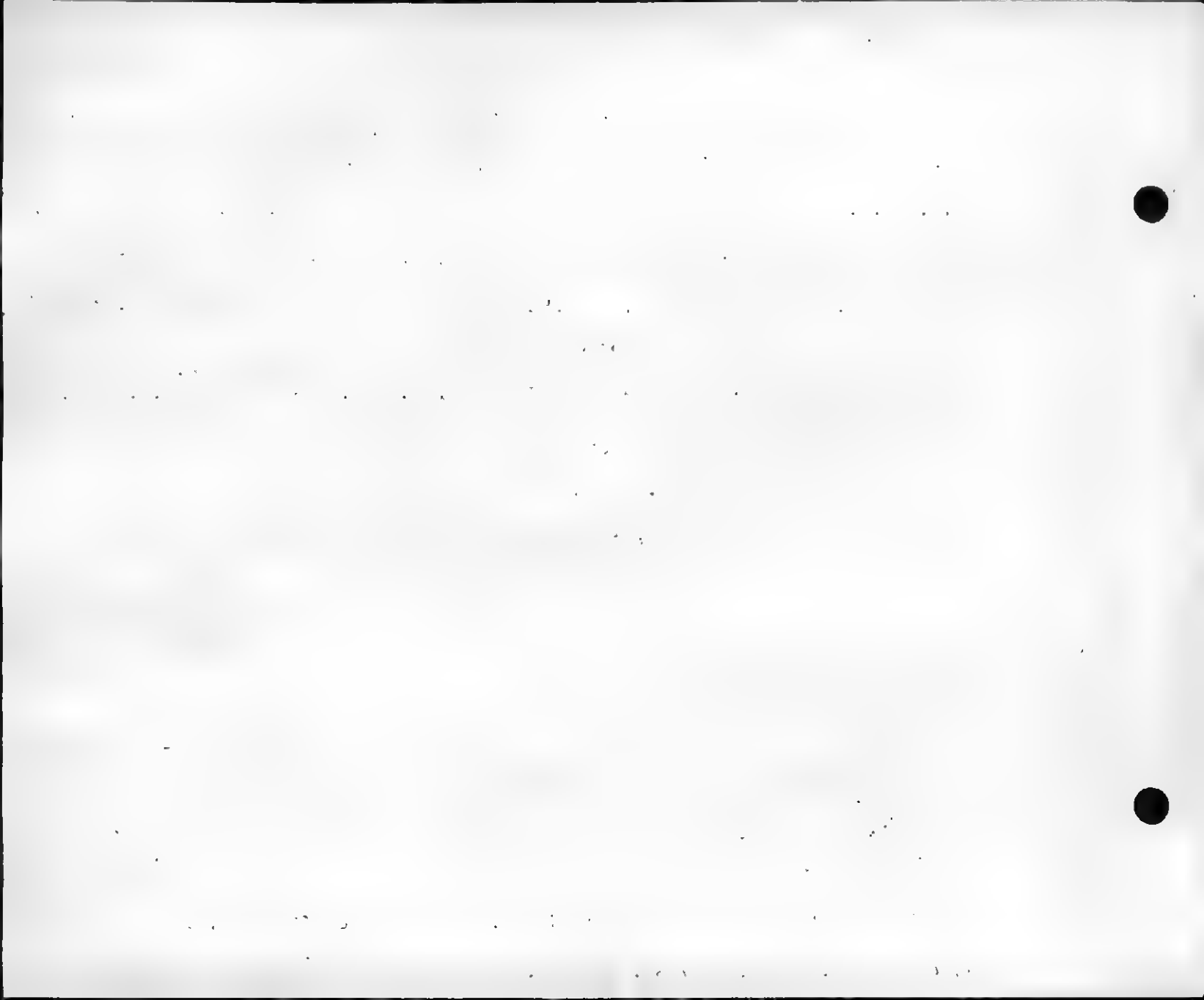


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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M
2

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|---|--|--|--|--|--|--|--|--|-----------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
Mildred | | | Middle
Harriet | | | Last
Neumann | | | 2a. DATE OF DEATH
Month 2 Day 27 Year 68 | | | 2b. HOUR
1:05p | | | | | |
| 3. SEX
Female | | | 4. RACE
Cau | | | 5. DATE OF BIRTH
June 28, 1898 | | | 6. AGE (in years
lost birthday)
69 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | IF UNDER 24 HRS. | | | | | |
| 7a. BIRTHPLACE (State or foreign
country)
N.Y., N.Y. | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Baltimore | | | Md | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital,
give street address)
Greater Balto., Medical Center | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired)
Housewife | | | 12b. KIND OF BUSINESS OR
INDUSTRY
Home | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before
admission) STATE
Md. | | | 13b. COUNTY
Balto. | | | 13c. CITY OR TOWN
Lutherville | | | 13d. INS DE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER
231 Cold Brook Rd. 21093 | | | | | | | | |
| 14. FATHER'S NAME
First ? Middle / Last Schroeder | | | 15. MOTHER'S MAIDEN NAME
First Unknown Middle Last | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) NO | | | 16b. SOCIAL SECURITY NO.
None | | | 17. INFORMANT
E Perry Fun. Dir. Long Island, N.Y. 11563 | | | 118 Union Ave. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Septicemia | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | |
| (b) Pancytopenia | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | |
| (c) Malignant lymphoma | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? YES | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(if either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/20, 1968, to 2/27, 1968, that (I) (we) last
saw the deceased alive on 2/27, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
John E. Adams | | | | | | | | | | | | DEGREE
M.D. | | | ATTENDING
PHYS. <input type="checkbox"/> MED.
DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
2/27/68 | | |
| 22d. PHYSICIAN'S
NAME (Type)
John E. Adams, M.D. | | | | | | | | | | | | 22e. ADDRESS
6701 N. Charles Street | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | | 23b. DATE
3-1-1968 | | | 23c. NAME OF CEMETERY OR CREMATORY
Greenfield Cem. | | | 23d. LOCATION (City or Town) (County) (State)
Hemfstead, N.Y. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Wm. Cook-Brooks, Inc. 1217 St. Paul St. 21202 | | | | | | | | | | | | 25a. REC'D BY REGISTRAR
DATE FEB 28 1968 | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

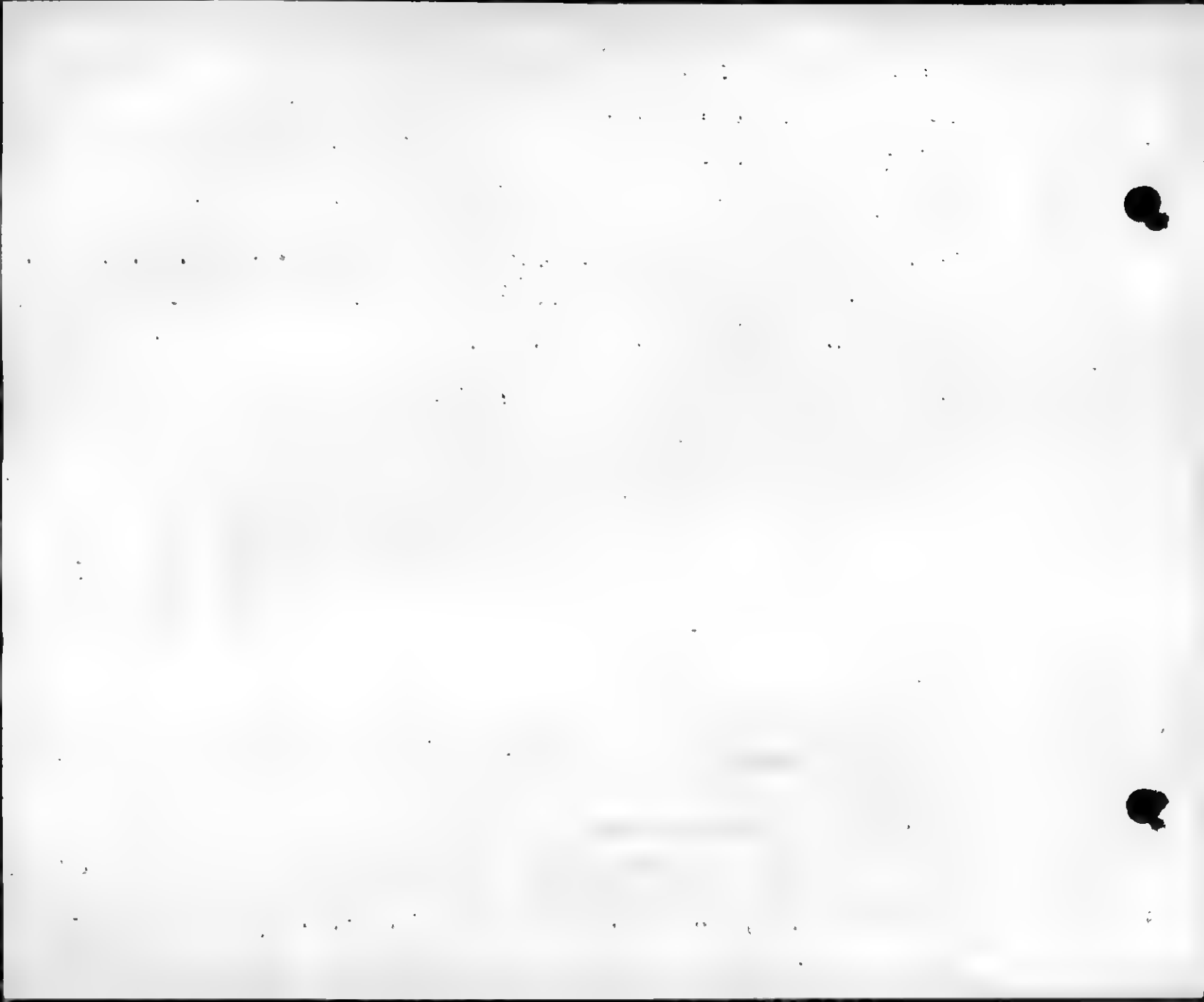


Page 4 may be retained by the hospital or attending physician.

1) FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

52

| <div> <div>52296</div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> </div> </div> | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|-----------------------------------|------------------------------|--|
| <div> <div>NEWCOMB EUGENE DEWEY</div> <div>CERTIFICATE OF DEATH</div> <div>6284</div> </div> | | | | | | | | | | | |
| 1 DECEASED-NAME
(Type or print)
NEWCOMB, EUGENE DEWEY | | | | | | 2a. DATE OF DEATH
2 Month 25 Day 68 Year | | | 2b. HOUR
1:50 PM | | |
| 3. SEX
MALE | | 4. RACE
CAU. | | 5. DATE OF BIRTH
23 12-26-01 | | 6. AGE (in years lost birthday)
66 YRS. | | IF UNDER 1 YEAR
MONTHS 1 DAYS 56 | | IF UNDER 24 HRS
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE Md | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
GREATER BALTO. MED. CENTER | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even retired)
RETIRED Dist., Jr. Milk Co. | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE
MD. | | 13b. COUNTY
BALTO. | | 13c. CITY
BALTO. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
110 LINDEN TERRACE | | | |
| 14. FATHER'S NAME
First Middle Last
JOHN DEWEY NEWCOMB | | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Mary Vickers | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) None | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
Family records Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Extensive liver metastasis
100-1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF (b) Bronchogenic Carcinoma
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or RFD No | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb. 1, 1968, to Feb. 25, 1968, that (I) (we) lost sow the deceased alive on Feb. 25, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Lilia C. Baldonado DEGREE | | | | | | ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2-25-68 | | | |
| 22d. PHYSICIAN'S NAME (Type) LILIA C. BALDONADO | | | | | | 22e. ADDRESS GREATER BALTO. MEDICAL CENTER | | | | | |
| 23a. BURIAL, CREMATION, REPOVA. (Specify) Burial | | 23b. DATE
Feb. 28, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley Memorial Cem. | | | | 23d. LOCATION (City or Town) (County) (State)
Cockeysville, Maryland | | | |
| 24. FUNERAL DIRECTOR
John Burns & Sons | | | | ADDRESS
Towson | | 25a. REC'D BY REGISTRAR
DATE FEB 29 1968 | | 25b. REGISTRAR'S SIGNATURE
James J. Jones | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MORTON & DYETT F.H. 1701 Laurens Street | | | | | | | | | |
|---|--|--|---|---|--|--|---|---|--|
| <div> <div>229</div> <div> <div>1</div> <div>2</div> </div> </div> <div> <div>2285</div> </div> | | | | | | | | | |
| 1 DECEASED-NAME (Type or print) | | | | | First Middle Last | | 20. DATE OF DEATH | | 2b HOUR |
| FRANK HOWARD NICKENS | | | | | | | Month 2- 19- 68 | | 6A |
| 3 SEX | | 4. RACE | | 5 DATE OF BIRTH | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| Male | | Negro | | 1-1-1903 | | 65 YRS | | | |
| 7a BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | |
| Virginia | | U.S.A. | | | | Balto Co. Md | | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| Catonville | | | Kidgeway Nursing Home | | | Cement finisher | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER |
| Maryland | | | | | Balto. | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 1921 Ettings Street |
| 14 FATHER'S NAME First Middle Last | | | | | 15 MOTHER'S MAIDEN NAME First Middle Last | | | | |
| UNKNOWN | | | | | UNKNOWN | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b SOC AL SECURITY NO | | 17. INFORMANT Address | | | | |
| No. | | | 218-01-1795 | | Mrs. Mary Gaulding 1921 Etting Street | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> | | | | | | | | | <u>Unknown</u> |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 9a DATE OF OPERATION | | 9b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | State |
| | | | | | | | | | |
| 22a I certify that () (th/s hospital) attended the deceased from <u>14 Feb</u> , 19 <u>68</u> , to <u>19 Feb</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>17 Feb</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>William Goodman M.D.</u> | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED D RECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED <u>17 Feb 68</u> | | |
| 22d. PHYSICIAN'S NAME (Type) <u>William Goodman M.D.</u> | | | | | 22e. ADDRESS <u>1334 Belvidere Rd SE 27</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 2-22-68 | | Mount Auburn Cem. | | Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| MORTON & DYETT F.H. 1701 Laurens Street | | | | | FEB 20 1968 | | <u>Charles Judge</u> | | |



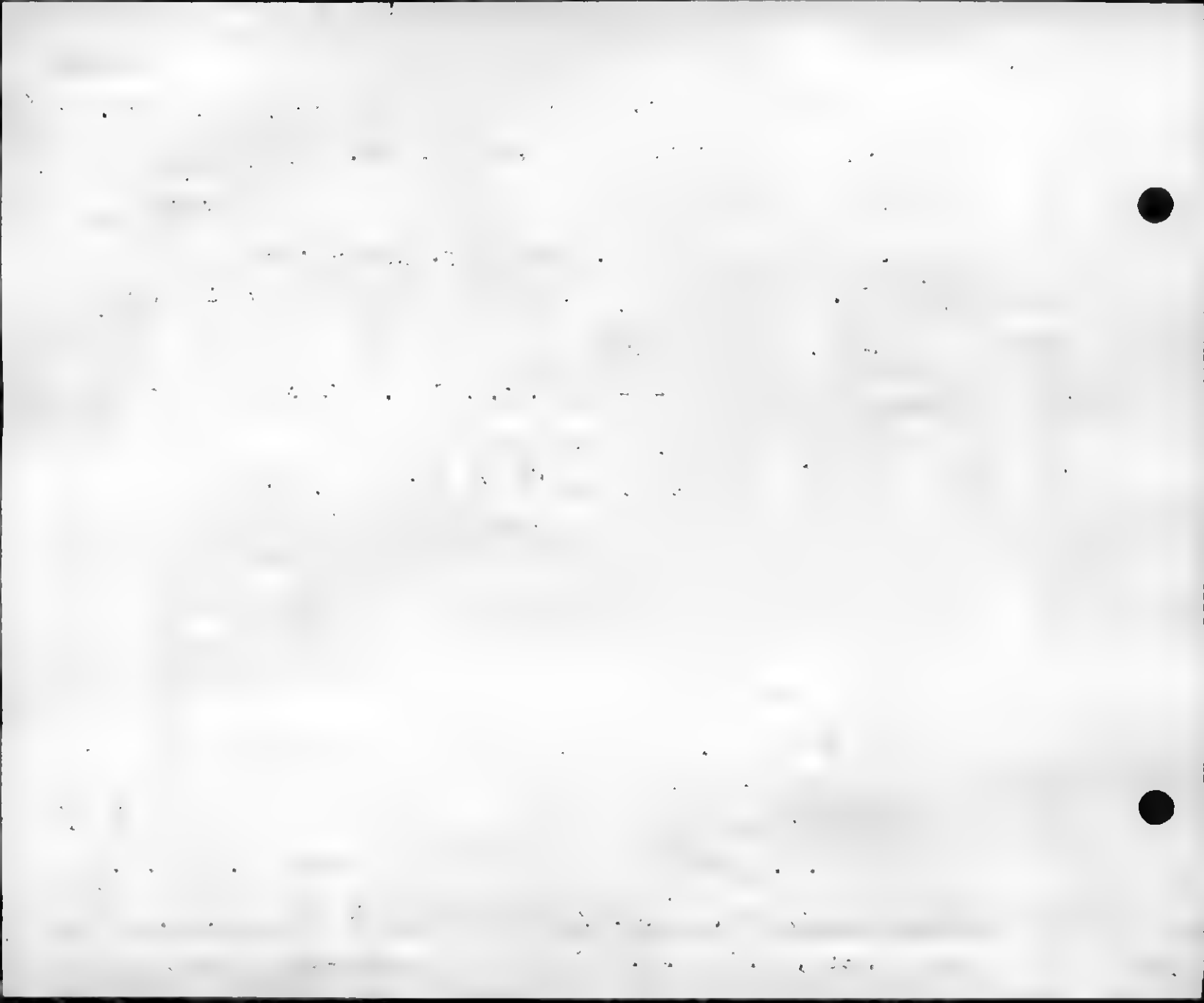
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VR A15 (4)
30M REV 1/68

| <div style="text-align: center;"> <div>02298</div> <div>02286</div> </div> <div style="text-align: center;"> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> </div> | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|-----------------------------|--|--|
| 1 DECEASED-NAME (Type or print) | | | First
WILLIAM | | | Middle
B. | | | Last
NOBLETTE | | | 2a DATE OF DEATH
February 20, 1968 | | | 2b HOUR
6:08 PM | | |
| 3 SEX
Male | | | 4 RACE
White | | | 5. DATE OF BIRTH
August 2, 1898. | | | 6 AGE (In years lost birthday)
69 YRS. | | | 7 UNDER 1 YEAR
MONTHS DAYS | | | 7 UNDER 24 HRS
HOURS MIN | | |
| 7a BIRTHPLACE (State or foreign country)
Maryland | | | 7b CITIZEN OF WHAT COUNTRY?
USA | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Baltimore Md | | | | | | | | |
| 10 CITY OR TOWN OF DEATH
Towson | | | 11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)
St. Josephs Hosp. | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Retired Mechanic | | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| 13a USUA. RES.DENCE (Where deceased lived, if institution, Residence before admission) STATE
Md. | | | 13b COUNTY
Baltimore | | | 13c CITY OR TOWN
Baltimore | | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e STREET AND NUMBER
5917 Falkirk Road | | | | | |
| 14 FATHER'S NAME First Middle Last
George Noblette | | | | | | 15 MOTHER'S MAIDEN NAME First Middle Last
Anna Storke | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No | | | 16b. SOCIAL SECURITY NO
579-07-5746 | | | 17 INFORMANT
Mrs. Emily S. Noblette | | | | | | Address
(Same) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic heart disease with</u>
stating the underlying cause lost (c) <u>hypertension</u> | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>one hour</u> | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>1949</u> | | | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>October 7, 1944</u> to <u>February 20, 1968</u> , that (H) (we) last saw the deceased alive on <u>February 20, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b SIGNATURE
<u>E. J. Alessi</u> | | | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | 22c DATE SIGNED
<u>2/22/68</u> | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
E. J. Alessi | | | | | | 22e. ADDRESS
6217 Harford Rd. Balto.Md. | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b DATE
2/24/68. | | | 23c NAME OF CEMETERY OR CREMATORY
Loyola Park Cemetery | | | 23d LOCATION (City or Town) (County) (State)
Baltimore, Md. | | | | | | | | |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Balto.Md. 21214 | | | | | | 25a. REC'D BY REGISTRAR
DATE <u>23 1968</u> | | | 25b REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | | | | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

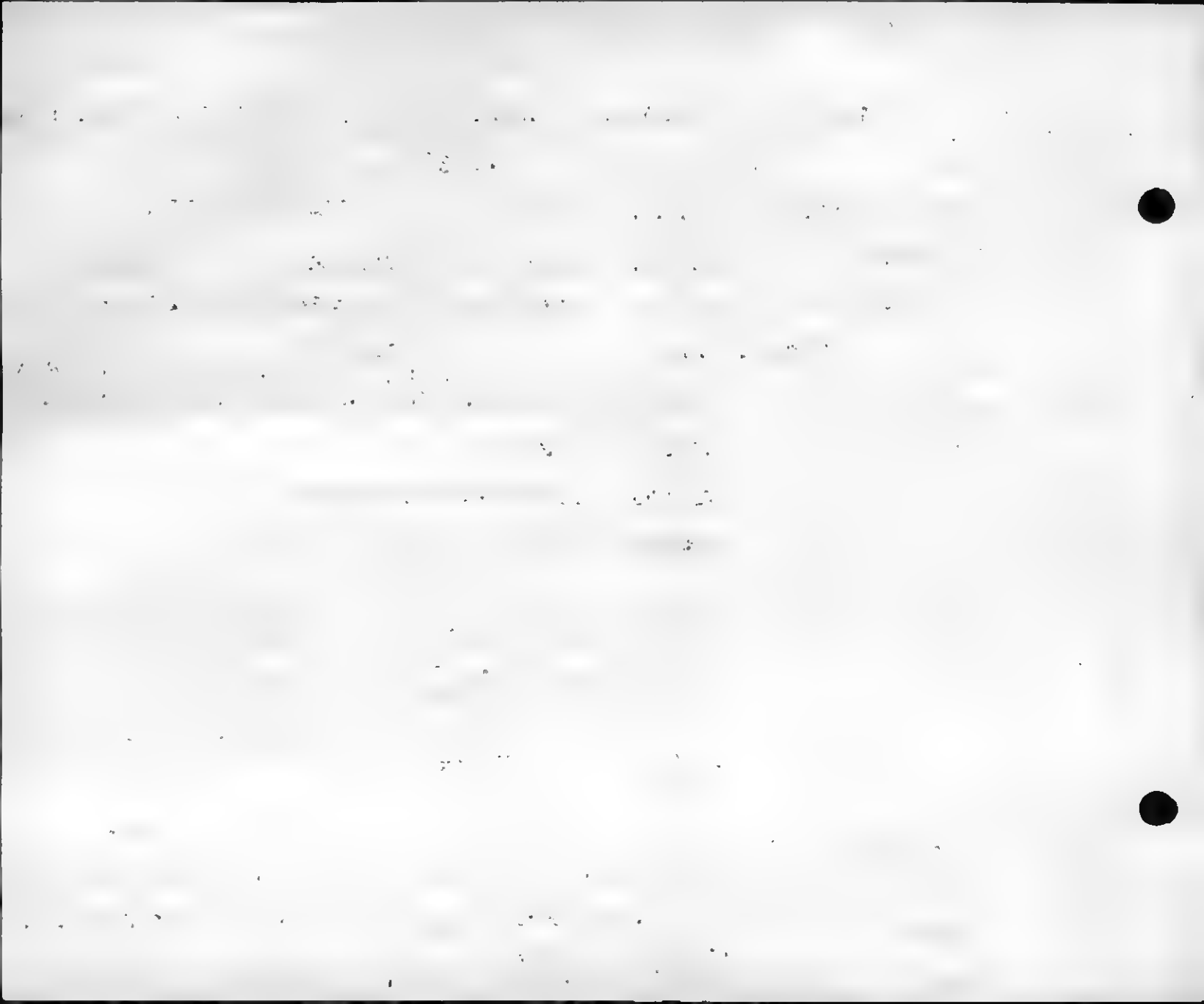
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VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

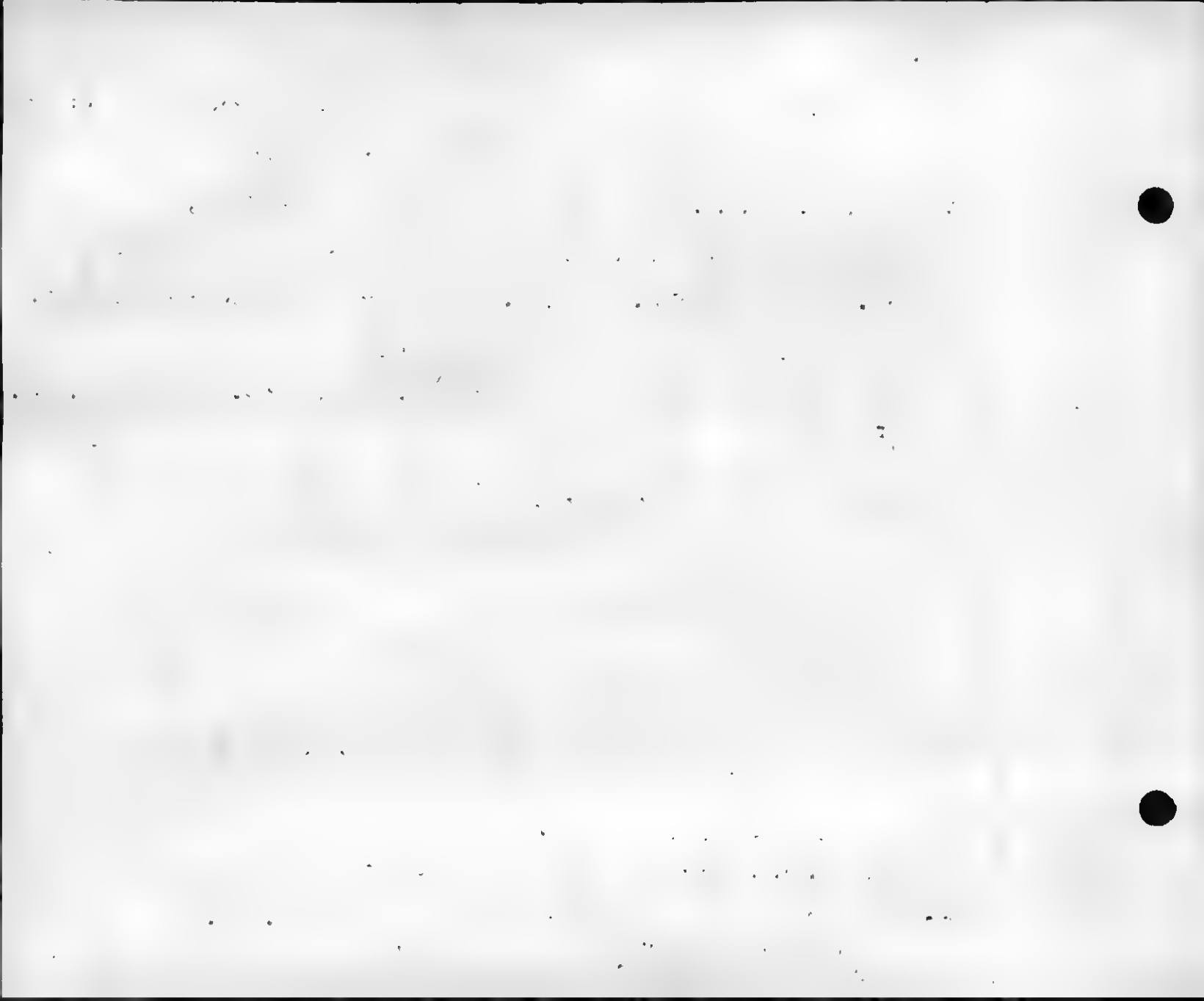
| | | | | | |
|---|--|--|--|--|--|
| 1 DECEASED-NAME (Type or print)
FRANK CASIMER NOVAK | | | 2a DATE OF DEATH
Month FEBRUARY Day 6 Year 1968 | | 2b HOUR
10:45 AM |
| 3 SEX
MALE | 4 RACE
WHITE | 5. DATE OF BIRTH
11/23/19 | | 6. AGE (In years last birthday)
48 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN |
| 7a BIRTHPLACE (State or foreign country)
BALTIMORE, MARYLAND | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
BALTIMORE COUNTY, Md | | |
| 10 CITY OR TOWN OF DEATH
FORT HOWARD | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp tal give street address)
VET. ADM. HOSPITAL | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
BARTENDER | 12b KIND OF BUSINESS OR INDUSTRY
TAVERN | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE
MARYLAND | 13b COUNTY
BALTIMORE | 13c CITY OR TOWN
BALTIMORE | 13d INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | 13e STREET AND NUMBER
2919 Putty Hill Road | |
| 14 FATHER'S NAME First Middle Last
CASIMER J. NOVAK | | 15. MOTHER'S MAIDEN NAME First Middle Last
ANNA CUSPER | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)
YES WW II | 16b SOCIAL SECURITY NO
212 09 21 47 | 17. INFORMANT Address
MARY JANE NOVAK 325 BLACKSTONE BLVD TOWSON, MD.
CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BACTERIAL SEPTICEMIA
DUE TO, OR AS A CONSEQUENCE OF
(b) BILATERAL CONFLUENT BRONCHOPNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF
(c) CIRRHOSIS OF LIVER | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a DATE OF OPERATION | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
YES | | |
| 21a ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | 21b TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | 21e PLACE OF INJURY (At home, farm, street, factory, office building etc.) | 21f. LOCATION Street or R.F.D. No | City or Town | County | State |
| 22a I certify that (a) (this hospital) attended the deceased from 1/17/68 , 19____, to 2/6/68 , 19____, that (b) (we) last saw the deceased alive on 2/6/68 , 19____, and that in (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (d) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE
John D. Talbert, M.D. | | DEGREE
M.D. | ATTENDING PHYS.
<input type="checkbox"/> | MED DIRECTOR
<input type="checkbox"/> | STAFF PHYS.
<input checked="" type="checkbox"/> |
| 22d PHYSICIAN'S NAME (Type)
JOHN D. TALBERT, M. D. | | 22e ADDRESS
VAH FORT HOWARD, MARYLAND | | 22c DATE SIGNED
2/6/68 | |
| 23a BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b DATE
2-10-1968 | 23c NAME OF CEMETERY OR CREMATORY
Sacred Heart of Mary Cemetery German Hill Rd. Balto. Md. | 23d LOCATION (City or Town) (County) (State)
BALTO. MD. | | |
| 24 FUNERAL DIRECTOR
KASZOROWSKI FUNERAL HOME | ADDRESS
2525 Fleet St. Baltimore, Md. | 25a. REC'D BY REGISTRAR
FEB 13 1968 | 25b REGISTRAR'S SIGNATURE
[Signature] | | |



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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
Rose Violet Novak | | | | | 2a. DATE OF DEATH
February 28, 1968 Year | | | 2b. HOUR
6:30 p.m. | |
| 3 SEX
female | | 4 RACE
white | | 5. DATE OF BIRTH
December 13, 1898 | | 6. AGE (In years lost birthday)
69 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore, Md | | | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
2806 Taylor Avenue #34 | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
at home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE
Md. | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
2806 Taylor Avenue 21234 | |
| 14. FATHER'S NAME First Middle Last
Theodore Seidel | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Mary Miller | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)
no | | 16b. SOCIAL SECURITY NO
none | | 17 INFORMANT (Nephew)
Charles J. Novak, 733 N. Patterson Pk. Ave. | | Address | | | |
| 18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) <u>Lobar pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF <u>Carcinomatous</u>
(b) <u>lymphatic system</u>
DUE TO, OR AS A CONSEQUENCE OF <u>Carcinoma of breast</u>
(c) <u>Carcinoma of breast</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 day</u>
<u>6 mos.</u>
<u>8 1/2 yrs.</u> | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 19 59</u> to <u>Feb. 28 19 68</u> , that (I) (we) last saw the deceased alive on <u>Feb. 28 19 68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>A. M. Bacon M.D.</u> | | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED
<u>3/1/68</u> | | |
| 22d. PHYSICIAN'S NAME (Type)
Dr. A.M. Bacon | | | | | 22e. ADDRESS
2810 Taylor Avenue | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3/2/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | | 23d. LOCATION (City or Town)
Balto., Md. | | (County) (State) | |
| 24. FUNERAL DIRECTOR
Schimunek Funeral Home
3331 Brehms Lane #13 | | | | | 25a. REC'D BY REGISTRAR
MAR 4 1968 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30A REV. 1/68

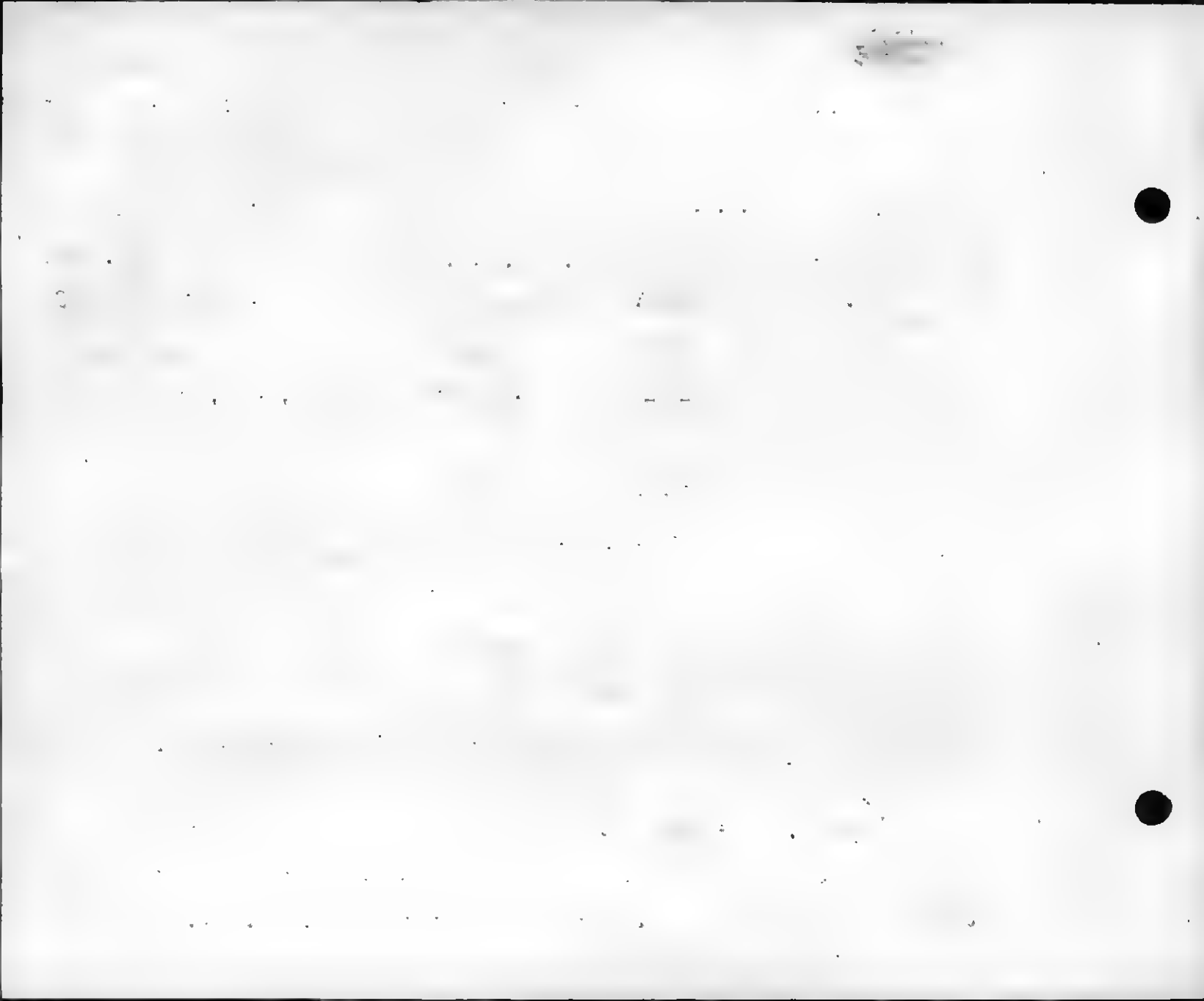
| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|-------------------------|--|-------------------------------------|--|---|--|--------------------------------|---|-------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) <i>Stephen X O'Dwyer</i> | | | | | | 2a. DATE OF DEATH
Month <i>2</i> Day <i>24</i> Year <i>1968</i> | | | 2b. HOUR
<i>10</i> M | | |
| 3 SEX
<i>Male</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>12/26/93</i> | | 6 AGE (In years last birthday)
<i>74</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
<i>New York City</i> | | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 COUNTY OF DEATH
<i>BALTO - County</i> Md. | | |
| 10. CITY OR TOWN OF DEATH
<i>Catonsville</i> | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Summit</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
<i>salesman</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE <i>MD</i> | | | 13b. COUNTY <i>BALTO.</i> | | | 13c. CITY OR TOWN
<i>Catonsville</i> | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME First Middle Last
<i>Thomas W O'Dwyer</i> | | | 15. MOTHER'S MAIDEN NAME First Middle Last
<i>Mary M Donald</i> | | | 13e. STREET AND NUMBER
<i>6 Locust Drive</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)
<i>Yes</i> | | | 16b. SOCIAL SECURITY NO.
<i>WWI 081-03-2727</i> | | | 17 INFORMANT
<i>Elizabeth O'Dwyer - Same</i> | | | Address | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Carcinoma of large intestine</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>8 mos.</i> | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>Rheumatoid Arthritis</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<i>AUG 1967</i> | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Carcinoma Rt Lung</i> | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
<i>16</i> | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1966</i> to <i>7-24-1968</i> , that (I) (we) last saw the deceased alive on <i>7-21-1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <i>I DID VIEW BODY AFTER DEATH.</i> | | | | | | | | | | | |
| 22b. SIGNATURE
<i>John N. Snyder MD</i> | | | | | | DEGREE
<i>MD</i> | | | 22c. DATE SIGNED
<i>2/24/68</i> | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>JOHN N. SNYDER M.D.</i> | | | | | | 22e. ADDRESS
<i>6348 FREDERICK RD CATONSVILLE MD</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | | | 23b. DATE
<i>2-28-68</i> | | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Baltimore NATIONAL</i> | | | 23d. LOCATION (City or town) (County) (State)
<i>BALTO. MD</i> | | |
| 24. FUNERAL DIRECTOR
<i>Ellsworth Armacost</i> | | | | | | ADDRESS
<i>4600 Liberty Hgts Ave</i> | | | 25a. REC'D BY REGISTRAR
DATE <i>FEB 27 1968</i> | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>02302</div> <div>022911</div> | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|-----------------------------------|------------------|--|
| <div>1 DECEASED NAME (Type or print)</div> <div>First Middle Last</div> <div>HANS OETTL</div> | | | | | | | | | | | |
| <div>2a DATE OF DEATH</div> <div>2b HOUR</div> <div>2 Month 22 Day 68 Year 11:35 PM</div> | | | | | | | | | | | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6 AGE (In years lost birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Male | | Cau. | | 9/20/97 | | 70 YRS | | MONTHS DAYS | | HOURS MIN. | |
| 7a BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | | | |
| Germany | | U.S.A. | | | | Baltimore | | Md | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Balto. Maryland | | | Greater Balto. Med. Cen. | | | Machinist | | | Beth. Steel | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b COUNTY | | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER | | |
| Md. | | | Baltimore | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 3416 Kenyon Avenue #13 | | |
| 14 FATHER'S NAME First Middle Last | | | | 15 MOTHER'S MAIDEN NAME First Middle Last | | | | | | | |
| Joseph Oetttl | | | | Anna Baumgartner | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT Address | | | | | |
| no | | | | 213-07-3515 | | Anna Oetttl (nee Ege), wife, above | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Aspiration | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Ileus | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Bronchopneumonia | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| Arteriosclerotic cardiovascular disease | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21b PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/5/1968, to 2/22/68, 1968, that (I) (we) last saw the deceased alive on 2/22 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | 22c. DATE SIGNED | | | |
| John E. Adams | | | | | | | | 2/23/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | |
| JOHN E. ADAMS, M.D. | | | | | | Greater Baltimore Medical Center | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | 2/26/68 | | Gardens of Faith Cemetery | | Balto., Md. | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE | | | |
| Schimunek Funeral Home 3331 Brehms Lane 21213 | | | | | | FEB 28 1968 | | Charles Judge | | | |



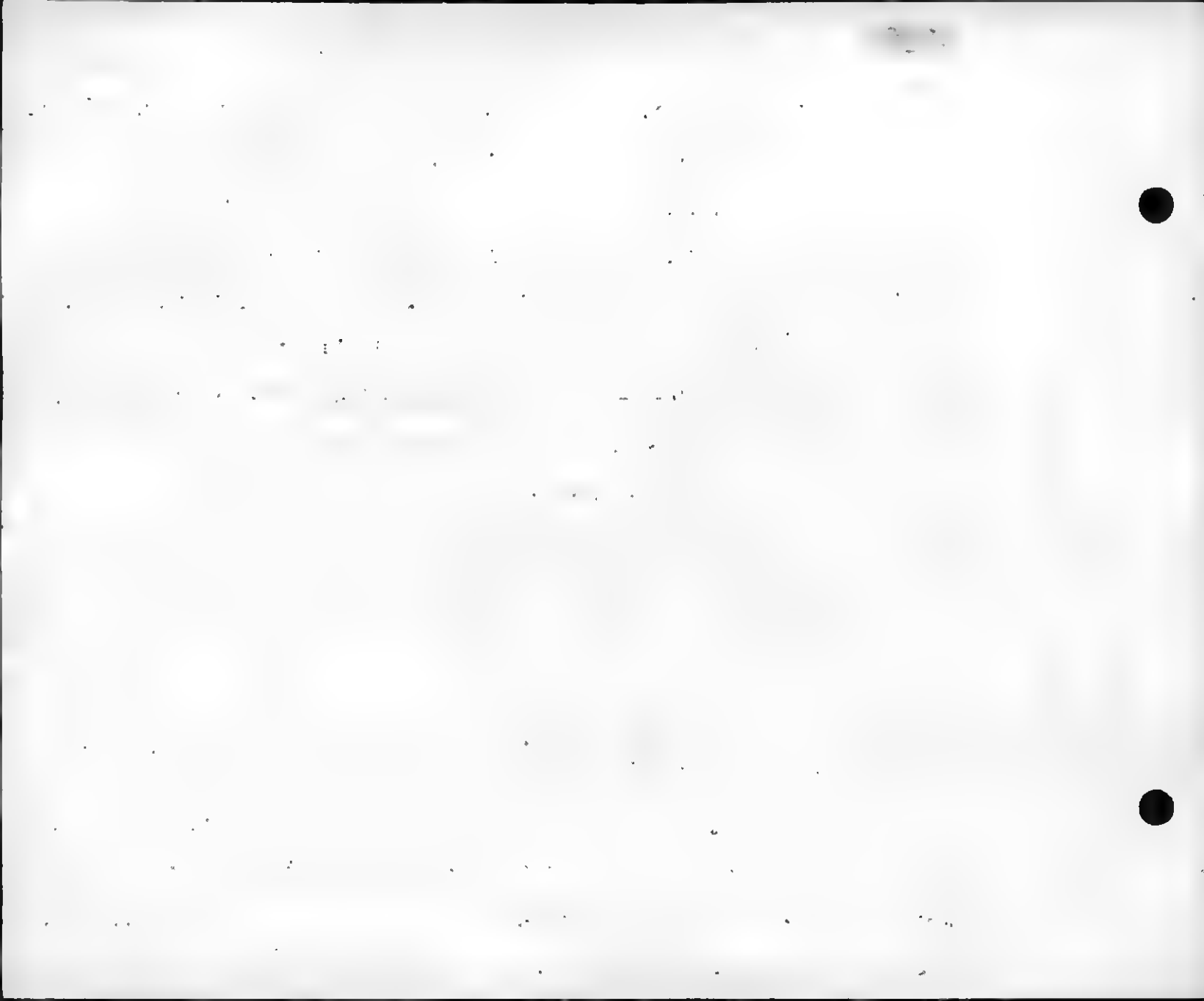
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14

VR A15 (4)
30M REV 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|--|--|---|--|---|---|--|---|------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
TERESA | | Middle
F. | | Last
OHLMEYER | | 2a. DATE OF DEATH
Month <u>February</u> Day <u>22</u> , Year <u>1968</u> | |
| 3. SEX
FEMALE | | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MAY 13, 1898 | | | 6. AGE (In years
last birthday)
69 YRS | | 2b. HOUR
1:15 |
| 7a. BIRTHPLACE (State or foreign
country)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE | | | Md | |
| 10. CITY OR TOWN OF DEATH
TOWSON | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
ST. JOSEPH HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
HOUSEWIFE | | | 12b. KIND OF BUSINESS OR
INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before
admission) STATE MARYLAND | | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
5204 A LOCH RAVEN BLVD. | |
| 14. FATHER'S NAME
First Middle Last
Robert Flanigan | | | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Louise Grebe | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) <u>no</u> | | | 16b. SOCIAL SECURITY NO.
216-44-0530 | | 17. INFORMANT
Address
Miss May Flanigan 5204 Loch Raven Blvd. | | | | | |
| 18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Recurrent myocardial infarction</u> | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (b) <u>coronary thrombosis</u> | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC) | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that <u>10</u> (this hospital) attended the deceased from <u>JANUARY 24</u> , 19 <u>68</u> , to <u>FEBRUARY 22</u> , 19 <u>68</u> , that <u>10</u> (we) last
saw the deceased alive on <u>FEBRUARY 22</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above. (I) (we) (did) (did not) view the body after death | | | | | | | | | | |
| 22b. SIGNATURE
<u>Reynaldo Orjuela-Gomez, M.D.</u> DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | | | | | | | 22c. DATE SIGNED
February 22, 1968 | | |
| 22d. PHYSICIAN'S NAME (Type)
Reynaldo Orjuela-Gomez, M.D. | | | | | | | | 22e. ADDRESS
7620 York Rd., Towson, Md. 21204 | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
burial | | 23b. DATE
2/26/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge | | | 23d. LOCATION (City or Town) (County) (State)
Balto., Md. | | | |
| 24. FUNERAL DIRECTOR
ADDRESS
Mitchell-Wiedefeld Home 6500 York Rd.
Baltimore, Md. 21212 | | | | | 25a. REC'D BY REGISTRAR
DATE FEB 26 1968 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

22304

Item 6 & 8 Film 2/19/68 kk

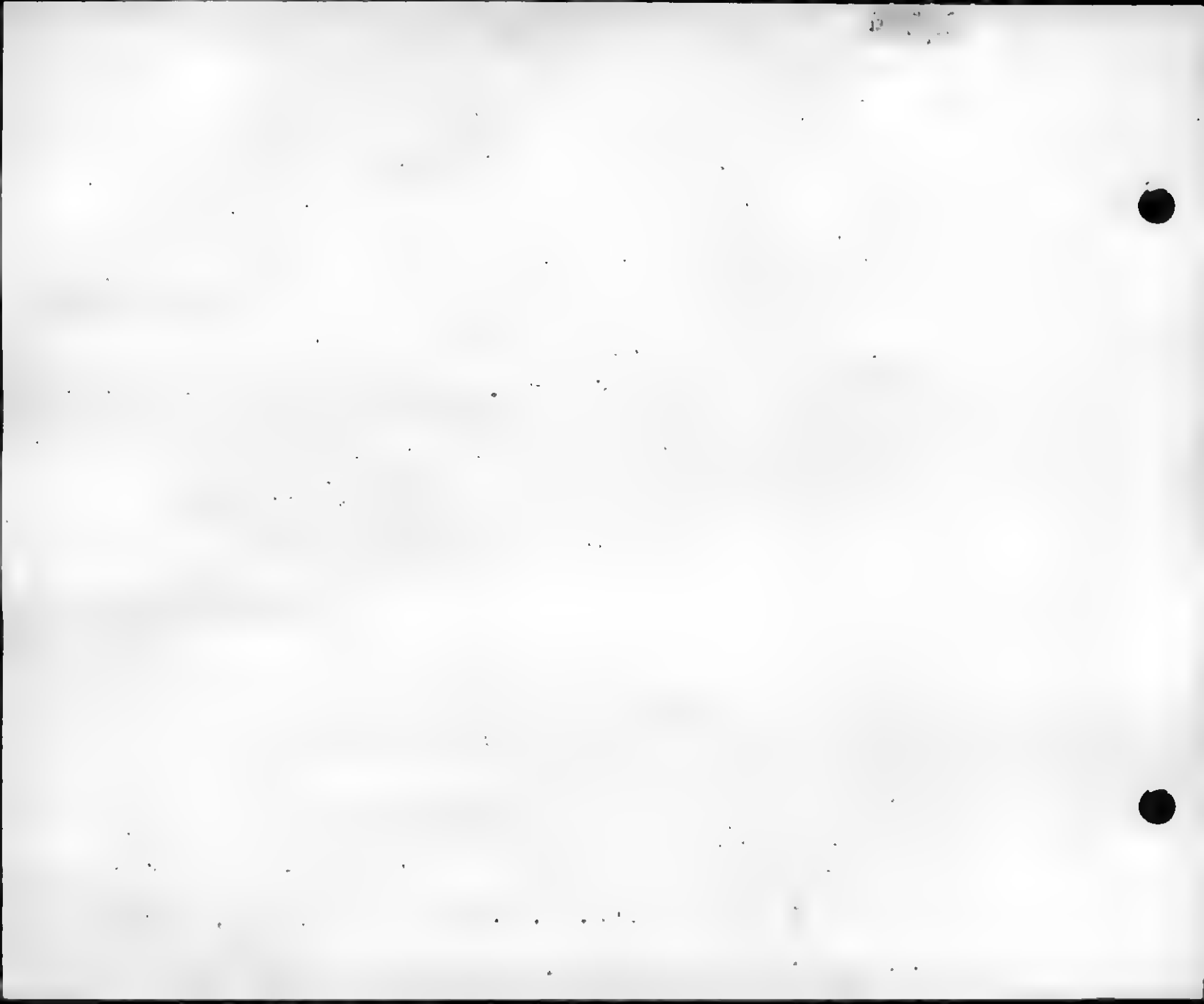
Item 13e Film G397 2/19/68 kk

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

22304

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(Type or print) <u>Joshua</u> | | First <u>Joshua</u> Middle <u>Cram</u> Last <u>Cram</u> | | 2a. DATE OF DEATH
Month <u>2</u> Day <u>9</u> Year <u>68</u> | | 2b. HOUR
<u>3:35</u> M | |
| 3. SEX
<u>Male</u> | | 4. RACE
<u>White</u> | | 5. DATE OF BIRTH
<u>Feb. 26, 1889</u> | | 6. AGE (In years lost birthday)
<u>78</u> YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
<u>UNKNOWN</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<u>Baltimore</u> Md. | |
| 10. CITY OR TOWN OF DEATH
<u>Catonsville Md</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<u>Forest Haven N.H.</u> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
<u>?</u> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <u>Md</u> | | 13b. COUNTY
<u>Baltimore</u> | | 13c. CITY OR TOWN
<u>Baltimore</u> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME First <u>John</u> Middle <u></u> Last <u>Cram</u> | | 15. MOTHER'S MAIDEN NAME First <u>Unknown</u> Middle <u></u> Last <u></u> | | 13e. STREET AND NUMBER
<u>711 Washington Boulevard</u> | | 13f. CITY AND STATE
<u>Baltimore, Md.</u> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown | | 16b. SOCIAL SECURITY NO.
<u>212-18-5404</u> | | 17. INFORMANT
<u>Forest Haven N.H.</u> | | Address
<u>315 Ingleside Ave</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Myocardial Infarction - Atherosclerosis</u> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (b) <u>Myocardial Infarction - Atherosclerosis</u> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (c) <u>Obesity</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/9</u> , 19 <u>63</u> , to <u>2-9</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Dr. John Shaw</u> | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>2/7/68</u> | |
| 22d. PHYSICIAN'S NAME (Type)
<u>Dr. John Shaw</u> | | | | 22e. ADDRESS
<u>5800 Edmondson Ave</u> | | | |
| 23a. BURIAL CREMATION, REBURY <u>Burial</u> | | 23b. DATE
<u>2-9-68</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Balto. Nat. Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore, Maryland</u> | |
| 24. FUNERAL DIRECTOR
<u>Wm. E. Johnson</u> | | | | ADDRESS
<u>8521 Loch Raven Blvd. 21204</u> | | 25a. REC'D BY REGISTRAR
<u>FEB 13 1968</u> | |
| | | | | 25b. REGISTRAR'S SIGNATURE | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|--|--|--|--|---|--|
| 1 DECEASED-NAME (Type or print)
First Middle Last
EDGAR JAMES O'ROURK | | | 2a. DATE OF DEATH
Feb. Month 5, Day Year 1968 6 th 9 th M | | | 2b. HOUR | | | |
| 3 SEX
Male | | 4 RACE
White | | 5 DATE OF BIRTH
Sept. 9, 1896 | | 6 AGE (In years last birthday)
71 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| 7a BIRTHPLACE (State or foreign country)
Penna. | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | |
| 10 CITY OR TOWN OF DEATH
Dundalk | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
20 Admiral Blvd. | | 12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired)
Machinist | | 12b KIND OF BUSINESS OR INDUSTRY
Steel | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c CITY OR TOWN
Dundalk | | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER
20 Admiral Blvd. | |
| 14 FATHER'S NAME First Middle Last
James W. O'Rourke | | | | 15 MOTHER'S MAIDEN NAME First Middle Last
Leah Rutter | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) | | 16b SOCIAL SECURITY NO | | 17 INFORMANT Address
Dr. Thomas R. O'Rourke 1101 W. Joppa Road. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)).
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>TERMINAL PNEUMONIA</u>
DUE TO, OR AS A CONSEQUENCE OF <u>PARKINSON'S Disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>3 days</u>
<u>5 years</u> | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>350 X</u> | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 19c. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>Feb 4</u> , 19 <u>68</u> , to <u>Feb 5</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Feb 4</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE
<u>M.B. Davis M.D.</u> | | | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (Type)
M.B. Davis, M.D. | | | |
| 22e. ADDRESS
6800 Morningside Road. 21222 | | | | | | | | | |
| 23a BURIAL OR CREMATION, REMOVAL (Specify)
Burial | | 23b DATE
Feb. 7, 1968 | | 23c NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | | 23d LOCATION (City or Town) (County) (State)
Woodlawn, Md. | | | |
| 24 FUNERAL DIRECTOR ADDRESS
Ullrich Funeral Home Dundalk, Md. | | | | 25a REC'D BY REGISTRAR
DATE FEB 13 1968 | | 25b REGISTRAR'S SIGNATURE | | | |

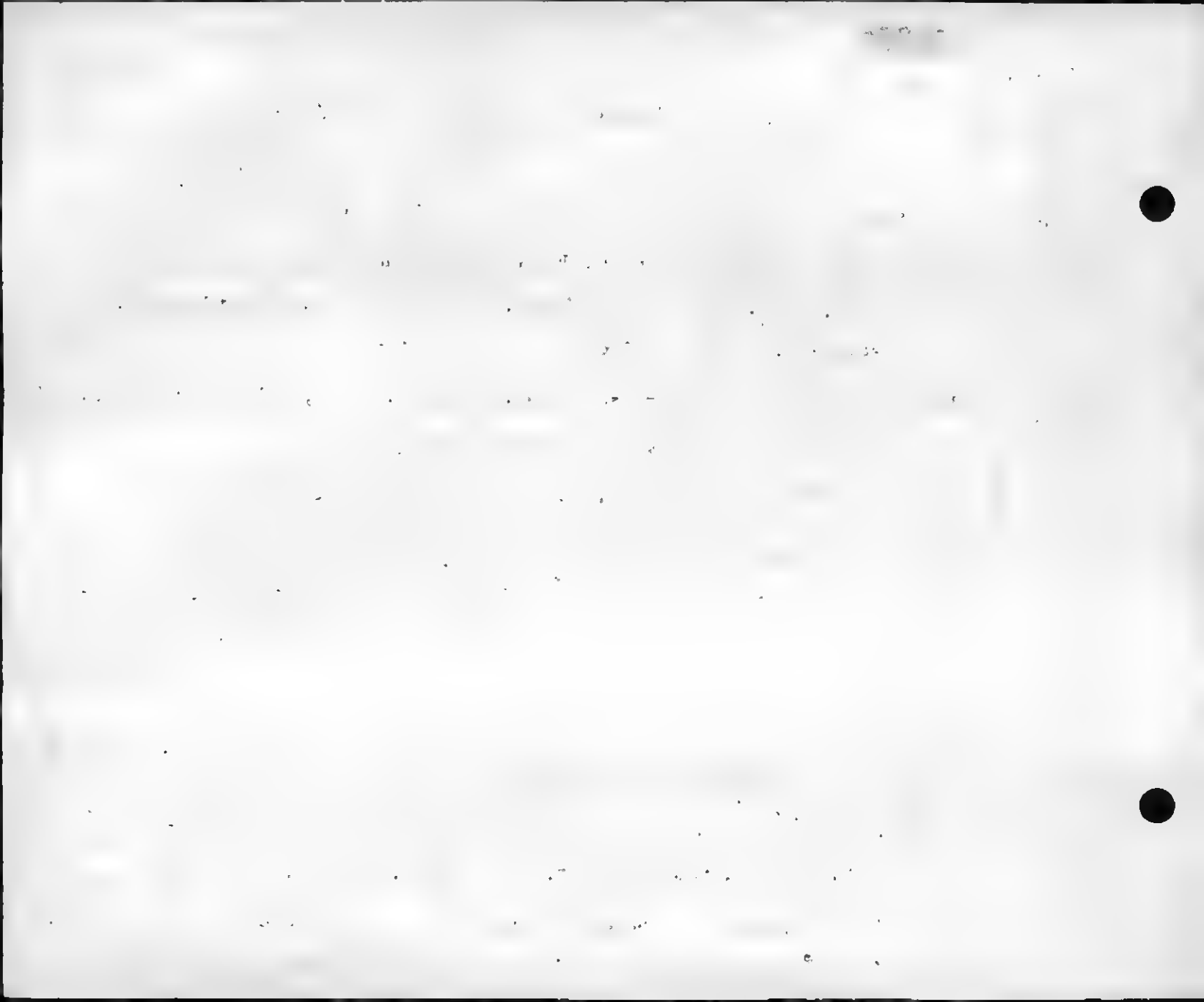


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

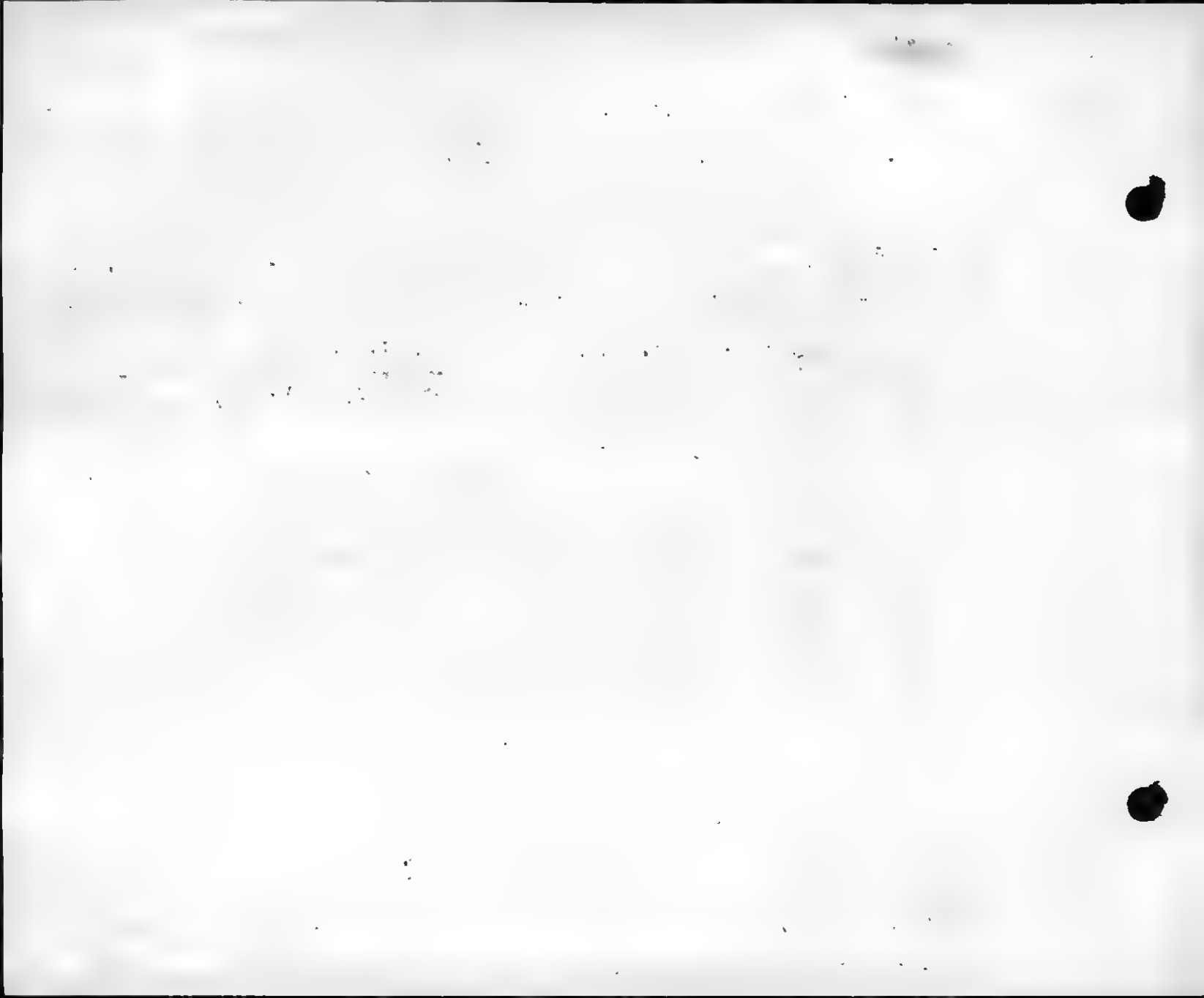
| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | |
|--|--|------------------------------|--|--|------------------------------------|--|---|---|--|--|-----------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | |
| Goldie Gertrude Owens | | | | | | 2/19/68 | | | M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Female | | White | | 2/16/89 | | | 79 YRS. | | MONTHS DAYS | | HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | |
| Maryland | | USA | | | | Baltimore Md | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Catonsville | | | Forest Haven Nursing Home | | | Homemaker | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Md. | | | — | | Balto. | | | | 3907 Old York Rd. | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | | |
| Marcellus Owens | | | Sarah A Bell | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | | |
| No | | | 216-09-2749 | | | Mr. Wilbur R. Owens, 3510 Coolidge Ave. 21229 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <i>Congestive heart failure</i> | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertension, severe generalized</i> | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic uraemic toxemia; cachexia decubitus</i> | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| <i>Chronic uraemic toxemia; cachexia decubitus</i> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED <input type="checkbox"/> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION | | | Street or R.F.D. No City or Town County State | | | |
| | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10 years</i> to <i>2/19/68</i> , that (I) (we) last saw the deceased alive on <i>June 25, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | | 22c. DATE SIGNED | | | |
| <i>Dr. Louis P. Hamburger, Jr.</i> | | | | | | | | | <i>2/20/68</i> | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | | |
| Dr. Louis P. Hamburger, Jr. | | | | | | 1001 St. Paul St. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | | 2/22/68 | | Savage Cemetery | | | Savage Md. | | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | | | | DATE FFB 23 1968 | | | <i>Charles J. Jones</i> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|---|--|---|---|--|----------------------------------|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
<i>William Carroll Parks</i> | | | | | 2a. DATE OF DEATH Month Day Year
<i>2 3 1968</i> | | 2b. HOUR MIN.
<i>11 P. M.</i> | | |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>6-19-08</i> | | 6. AGE (In years lost birthday)
<i>59</i> YRS | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Baltimore</i> Md. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Towson</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>G.B.M.C.</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
<i>Attorney</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Self-Employed</i> | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE
<i>Md.</i> | | 13b. COUNTY
<i>Baltimore</i> | | 13c. CITY OR TOWN
<i>Baltimore</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>2786 White Ave</i> | |
| 14. FATHER'S NAME First Middle Last
<i>Carmel Landon Parks</i> | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
<i>Bessie Cox</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? <i>No</i> | | 16b. SOCIAL SECURITY NUMBER
<i>2146057203</i> | | 17. INFORMANT
<i>Mrs. Edna F. Parks</i> | | Address
<i>Same</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Ch of the lungs - secondary to</i>
DUE TO, OR AS A CONSEQUENCE OF <i>brain + bone</i>
(b) _____
DUE TO, OR AS A CONSEQUENCE OF _____
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>163v</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year
<i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING ETC.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Sept. 4, 1967</i> , to <i>Feb. 3, 1968</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Marston L. John</i> | | | | DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<i>Feb 3, 1968</i> | | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>Marston L. John</i> | | 22e. ADDRESS
<i>G.B.M.C.</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>2/7/68</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Parkwood</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Baltimore Maryland</i> | | | |
| 24. FUNERAL DIRECTOR
<i>Leonard J Ruck Inc Baltimore Md</i> | | | | 25a. REC'D BY REGISTRAR
DATE <i>5 1968</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Marston L. John</i> | | | |

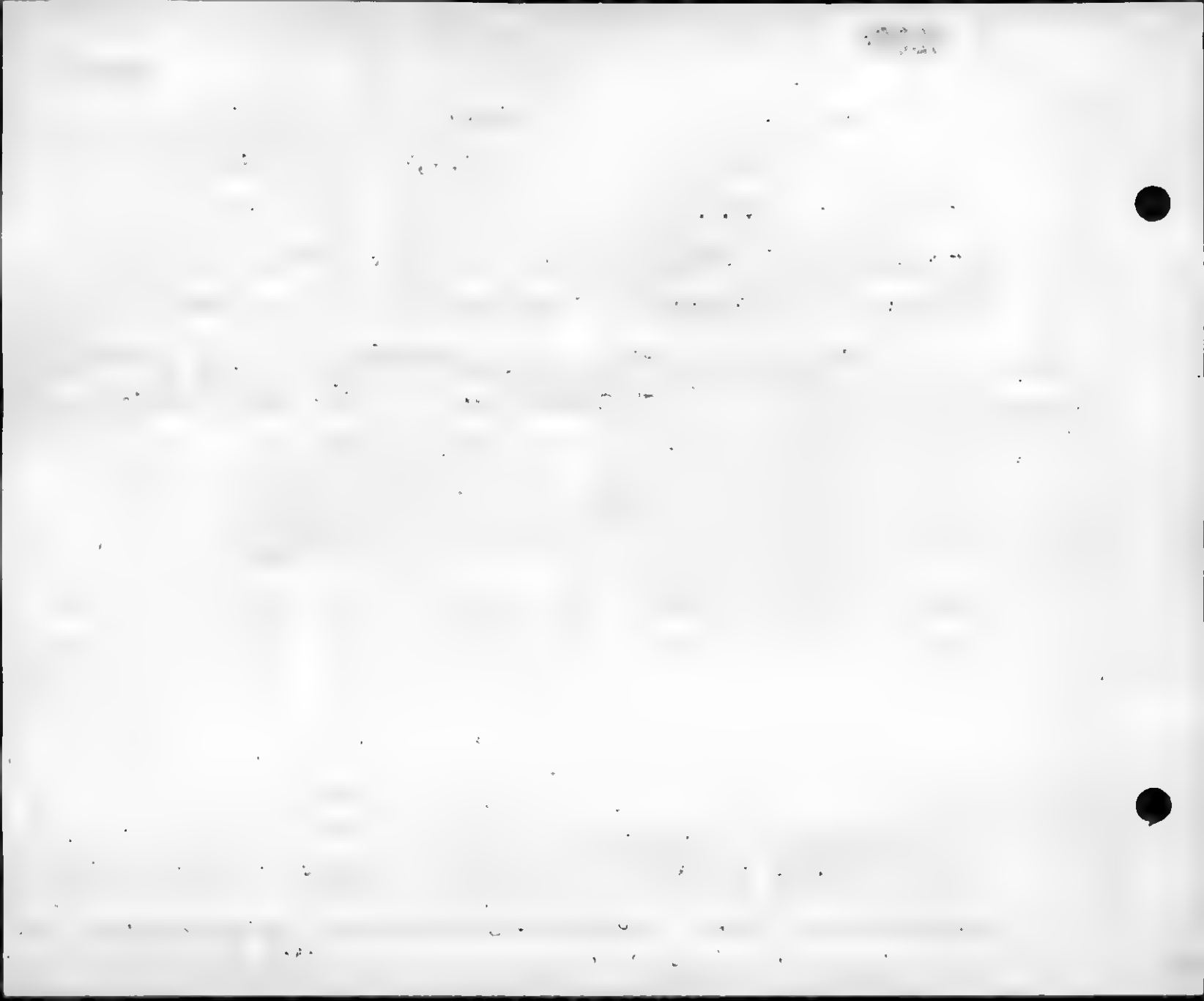


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) A
30M REV 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | |
|---|--|--|---|--|-----------|--|------|--|---|--|--------|-------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1 DECEASED NAME (Type or print) | | | First | | Middle | | Last | | 2a DATE OF DEATH | | | |
| Rosa | | | M. | | Patterson | | | | Month 2 Day 2 Year 68 | | | |
| 3 SEX | | | 4 RACE | | | 5 DATE OF BIRTH | | | 6 AGE (in years last birthday) | | | |
| Female | | | White | | | Sept. 26, 1877 | | | 90 YRS. | | | |
| 7a BIRTHPLACE (State or foreign country) | | | 7b CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 COUNTY OF DEATH | | | |
| Maryland | | | U.S.A. | | | | | | Baltimore Md | | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| Parkville | | | 2718 Glendale Rd | | | Housewife | | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution on residence before admission) STATE | | | 13b COUNTY | | | 13c CITY OR TOWN | | | 13d INSIDE CITY - YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| Maryland | | | Baltimore | | | Parkville | | | 2718 Glendale Rd | | | |
| 14. FATHER'S NAME | | | 15 MOTHER'S MAIDEN NAME | | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | | |
| Samuel G Leight | | | Pricilla Osborn | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b SOCIAL SECURITY NO | | | 17 INFORMANT | | | Address | | | |
| No | | | 216-07-5412A | | | Mrs. Ruth Smith | | | (Same) | | | |
| 18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS | | | | | | | | | | IMMEDIATE | | |
| 433.4 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| (b) ARTERIO SCLEROSIS | | | | | | | | | | 10 YRS. | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | | | | | | | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f LOCATION Street or R.F.D. No | | | City or Town | | County | State |
| | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/10, 1964, to 2/2, 1968 that (I) (we) last saw the deceased alive on 2/2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b SIGNATURE | | | 22c DATE SIGNED | | | | | | | | | |
| Leonard Paul Berger M D | | | 2/2/68 | | | | | | | | | |
| 22d PHYSICIAN'S NAME (Type) | | | 22e ADDRESS | | | | | | | | | |
| Leonard Paul Berger M D | | | 8100 Harford Rd Baltimore Md 21234 | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | | 2/5/68. | | | Providence Cemetery | | | Gamber, Md. | | | |
| 24 FUNERAL DIRECTOR | | | ADDRESS | | | 25a REC'D BY REGISTRAR | | | 25b REGISTRAR'S SIGNATURE | | | |
| Leonard J Ruck Inc | | | Baltimore Md | | | DATE FEB 5 1968 | | | Charles Judge | | | |



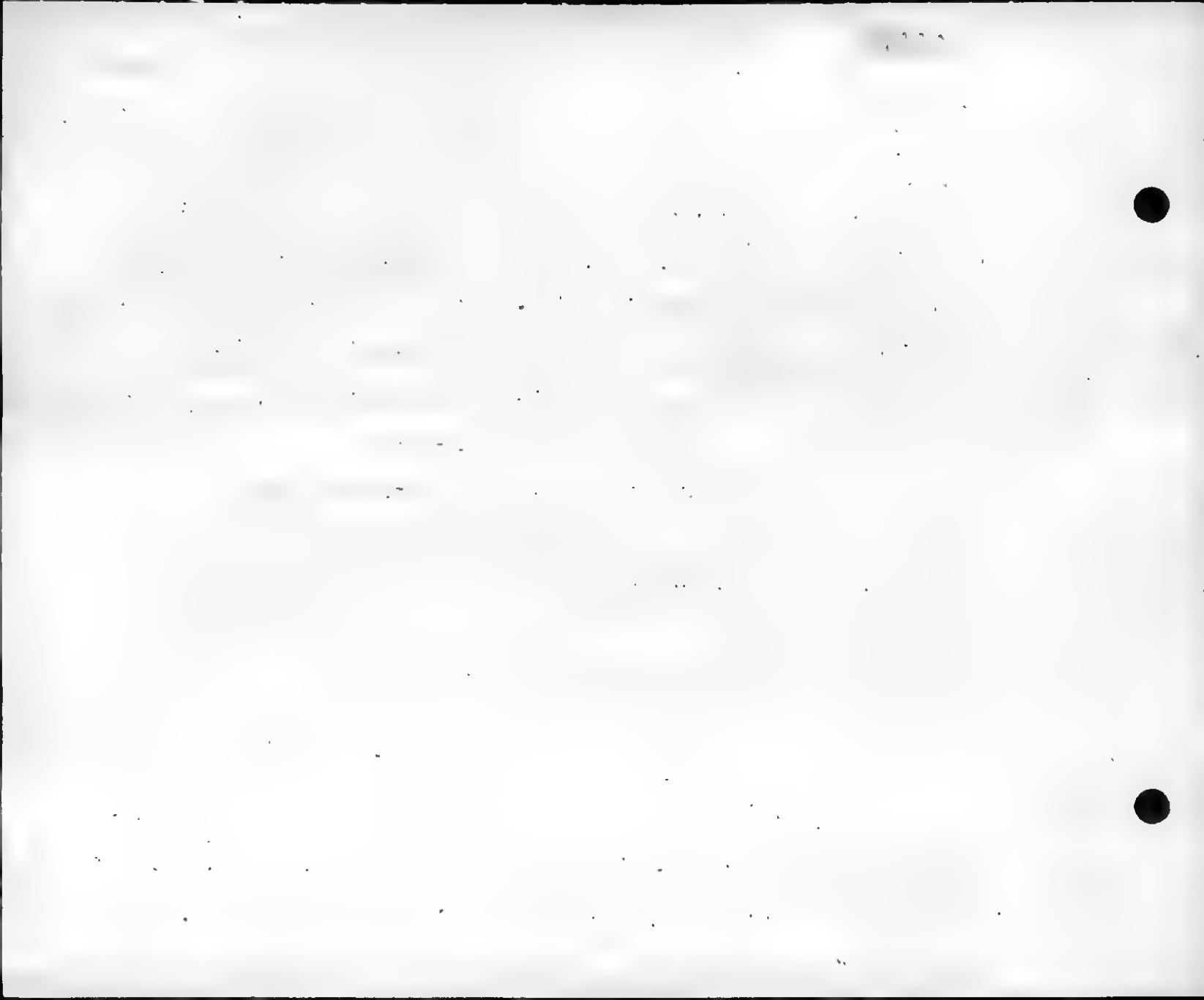
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)-
30M REV 1/68

MEDICAL CERTIFICATION

| MAY 1968 | | | | | | | | | |
|--|--|--|-----------------------------------|--|---|---|--|----------------------------|--|
| <div style="text-align: center;"> 02309
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 CERTIFICATE OF DEATH </div> | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Anna | | | Pazourek | | | Month Day Year
February 18 1968 | | 4:45 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | 7. UNDER 1 YEAR | |
| Female | | White | | 8-21-89 | | 78 YRS | | MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Maryland | | U.S.A. | | | | Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Towson | | St. Joseph Hospital | | HOUSEWIFE | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | BALTO | | Baltimore | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 115 Riverside Rd. | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last
JOHN KALAL | | | First Middle Last
BARBARA SVEC | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | |
| NO | | | | | PAUL PAZOUREK | | ABOVE | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Acute Myocardial Infarction | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (b) Arteriosclerotic Cardiovascular disease | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| Minimal Pulmonary Edema | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| | | HOUR A.M. Month Day Year
P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. | | | 21f. LOCATION | | City or Town County State | | |
| | | | | | Street or R.F.D. No | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>1/28</u> , 19 <u>68</u> , to <u>2/18</u> , 19 <u>68</u> , that (X) (we) last saw the deceased alive on <u>2/18</u> , 19 <u>68</u> , and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | 22c. DATE SIGNED | |
| | | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 2/18/68 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | |
| Samuel Lee, M.D. | | | | | | 7520 York Rd., Towson, Md. 21204 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| BURIAL | | 2/22/68 | | SACRED HEART | | BALTO. MD. | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| J.B. CONNELLY SONS | | | | | | 300 MALE | | DATE FEB 21 1968 | |

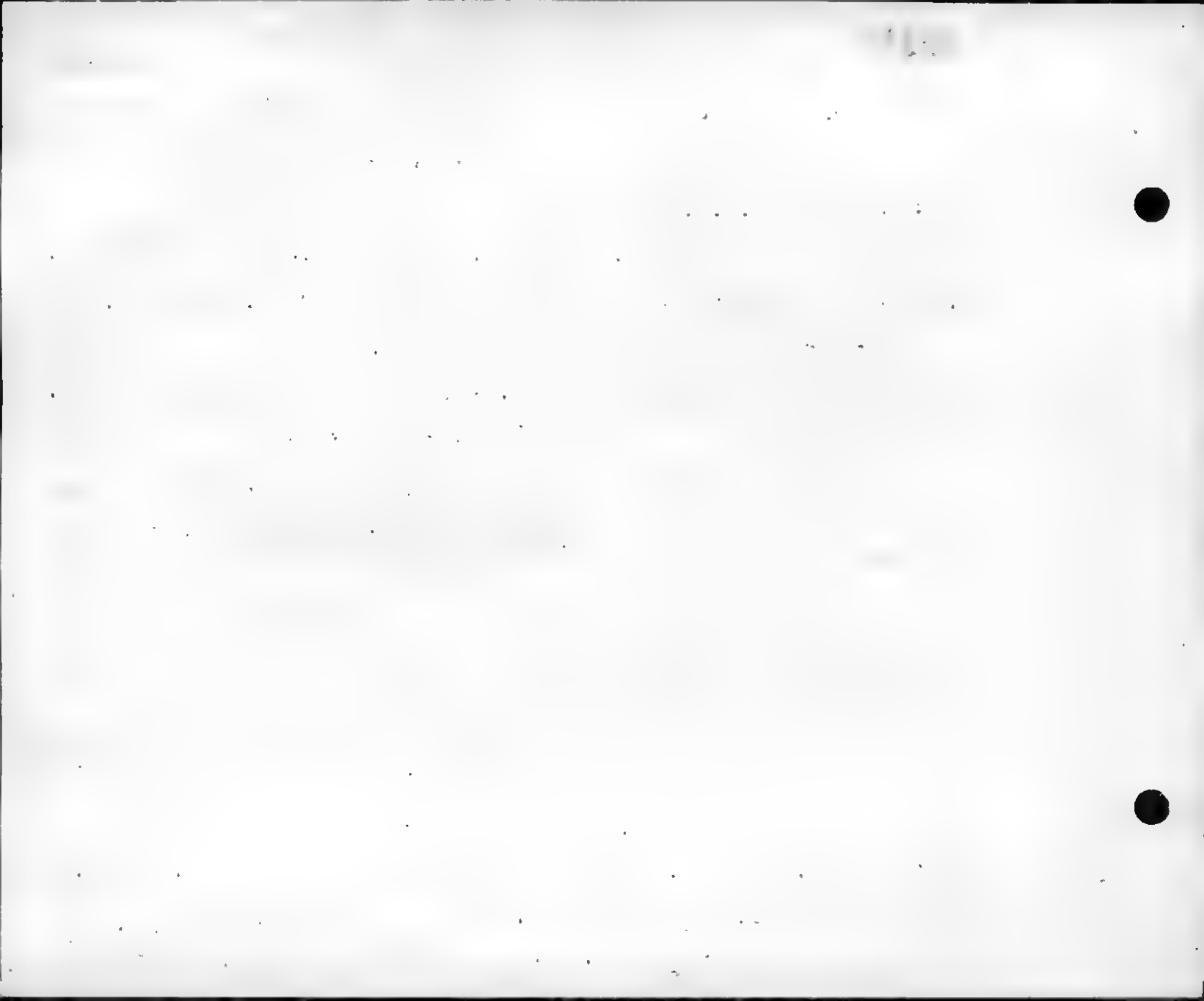


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/58

| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 CERTIFICATE OF DEATH </div> | | | | | | | | | | | |
|--|--|------------------------------|--|--|------------------------------------|--|---------------------------------|--|--|--|------------------|
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| ELEANOR RILEY PECK | | | | | | FEBRUARY 15, 1968 | | | M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| FEMALE | | WHITE | | OCT. 6, 1897 | | | 70 YRS | | MONTHS DAYS | | HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| MARYLAND | | U.S.A. | | | | BALTIMORE Md | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| TOWSON | | | 204 E. JOPPA RD. | | | PRESIDENT | | | SAW MFG. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Res. den. before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| MARYLAND | | | BALTIMORE | | | TOWSON | | | | 204 E. JOPPA RD. | |
| 14. FATHER'S NAME First Middle Last | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | |
| ROBERT OLIVER MATTHEWS | | | | ROSA M. DAVIS | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | |
| NO | | | 219-22-6994 | | | MR. GWYNN PECK | | | 322 WORTHINGTON RD. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 4121 Cardiac arrest | | | | | | | | | | minutes | |
| Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | years | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | Myocardial Infarction(s) years. | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from January, 1967, to 2/15, 1968, that (I) (we) last saw the deceased alive on 2/23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (d) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE James R. Karns MD | | | | | | 22c. DATE SIGNED 2/16/68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) DR. JAMES R. KARNs | | | | | | 22e. ADDRESS XXX 800 CATHEDRAL ST. BALTO., MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| BURIAL | | | 2-19-68 | | DULANEY VALLEY | | | COCKEYSVILLE, MD. | | | |
| 24. FUNERAL DIRECTOR MITCHELL-WIEDEFELD HOME, INC. 6500 YORK ROAD BALTIMORE, MD. 21212 | | | | | | 25a. REC'D BY REGISTRAR DATE FEB 21 1968 | | | 25b. REGISTRAR'S SIGNATURE Charles J. [Signature] | | |



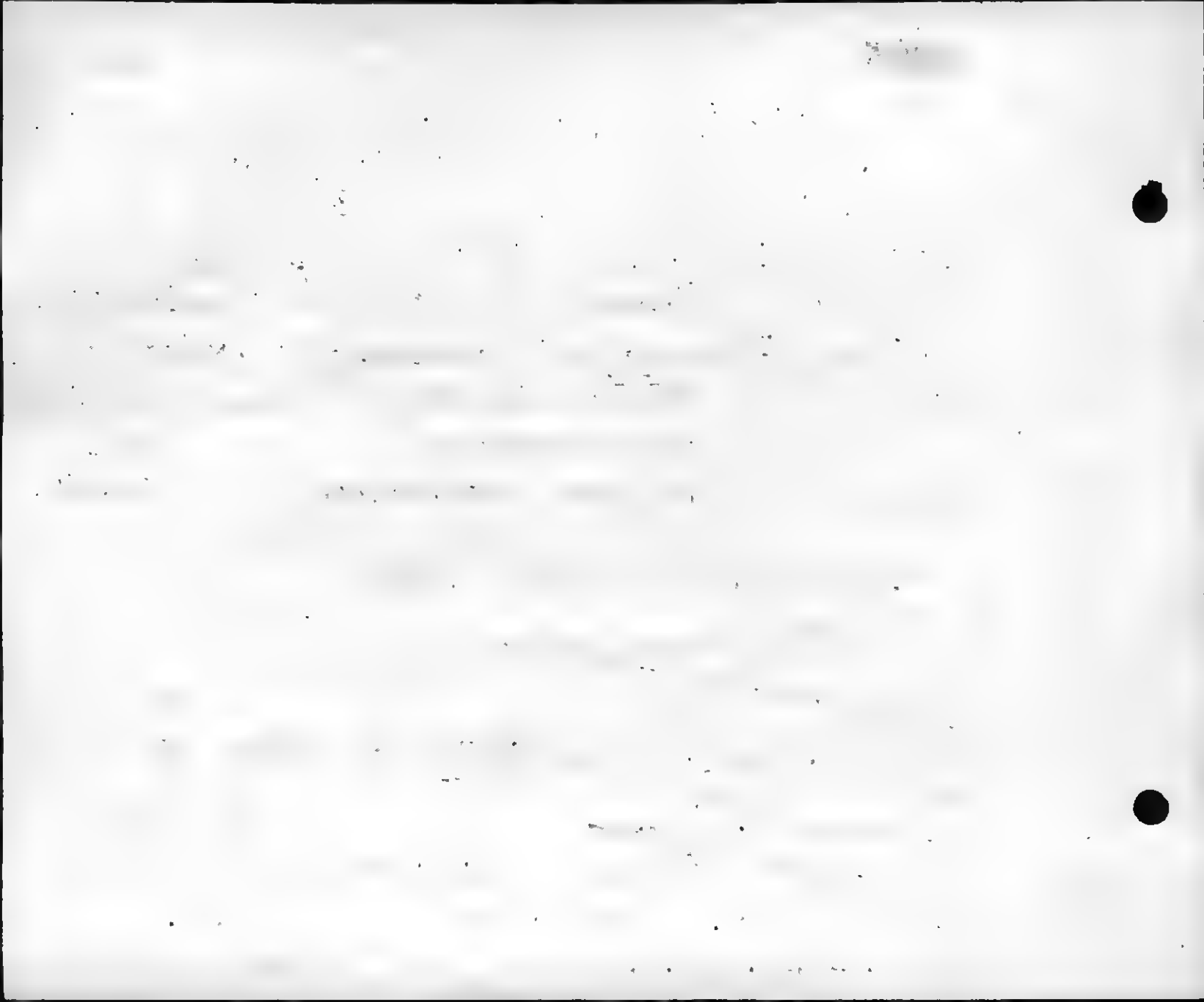
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (7)
304 REV 1/68

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | |
|---|---|--|---|--|
| 1. DECEASED-NAME (Type or print) Sadye Elizabeth Pennington | | 2a. DATE OF DEATH
Month 2 Day 26 Year 68 | | 2b. HOUR 2:45 PM |
| 3. SEX Female | 4. RACE cau. | 5. DATE OF BIRTH 9-18-88 | 6. AGE (In years lost birthday) 79 YRS | 7. UNDER 1 YEAR MONTHS 7 DAYS 9 |
| 7a. BIRTHPLACE (State or foreign country) Baltimore Md. | 7b. CITIZEN OF WHAT COUNTRY? USA. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH Baltimore Md. | |
| 10. CITY OR TOWN OF DEATH Baltimore Md. | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greater Baltimore Medical Center | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUA. RES DENCE (Where deceased lived, if institution; Res dence before admission) STATE md. | 13b. COUNTY Balto | 13c. CITY OR TOWN md | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER 2900 Westfield Ave |
| 14. FATHER'S NAME First John Middle Patterson Last (dec) | | 15. MOTHER'S MAIDEN NAME First Ella J. Middle Schuman Last Varnes | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No | 16b. SOCIAL SECURITY NO. 216-10-6582A | 17. INFORMANT Mrs. Alberta Coleman Address (same as patient's) | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF (b) MULTIPLE MYELOMATOSIS
DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC HEART DISEASE | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days
3 months |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. 19 Month 2 Day 26 Year 68 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No 616, E 34th City or Town BALTIMORE County Zone 18 State Md. | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/27 , 19 67 , to 2/26 , 19 68 , that (I) (we) last saw the deceased alive on 2/26 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE Duncan D. McGhie | | DEGREE MD. | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | 22c. DATE SIGNED 2/26/68 |
| 22d. PHYSICIAN'S NAME (Type) DUNCAN MCGHIE | | 22e. ADDRESS 616, E 34th ST. BALTIMORE Zone 18 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 2/29/68. | 23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery | 23d. LOCATION (City or Town) (County) (State) Madonna, Md. | |
| 24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 | | ADDRESS BALTO 27 | 25a. REC'D BY REGISTRAR 1968 | 25b. REGISTRAR'S SIGNATURE Charles Judge |

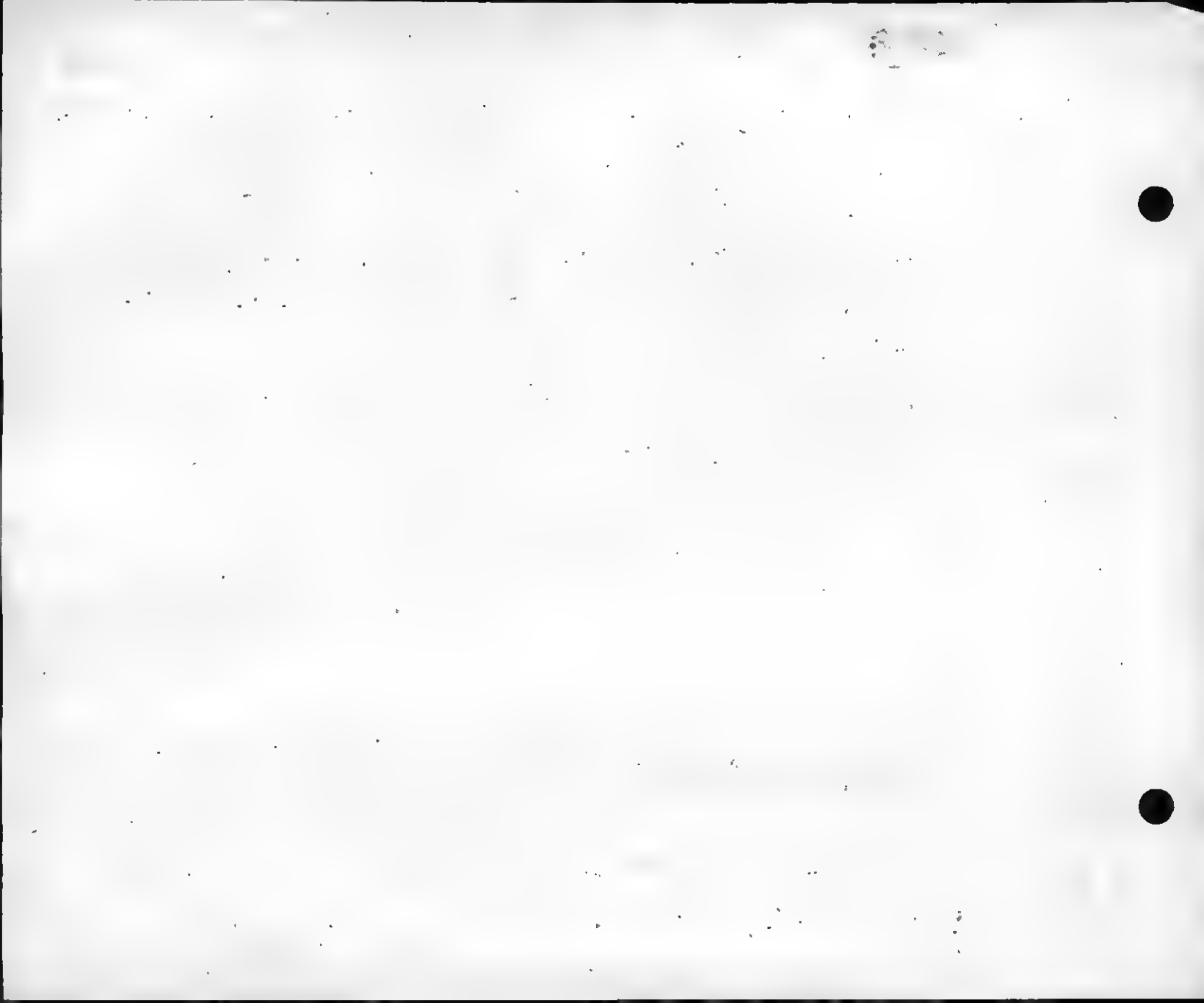


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| <div style="text-align: center;"> 32312
 <div style="display: flex; justify-content: space-between;"> <div> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 CERTIFICATE OF DEATH </div> <div style="text-align: right;"> 32310 </div> </div> </div> | | | | | | | | | |
|---|--|---|--|---|---|--|---|---|--|
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| EDWIN | | | H. PERKINS | | | February 26 1968 | | 6:30 P.M. | |
| 3 SEX | | 4. RACE | | 5 DATE OF BIRTH | | 6 AGE (in years last birthday) | | 7 UNDER 1 YEAR | |
| Male | | White | | 6/18/1892 | | 75 YRS | | MONTHS DAYS HOURS MIN | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | |
| Maryland | | U.S. | | | | Baltimore Md | | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| Towson | | | St. Joseph Hospital | | | RETIRED | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b COUNTY | | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| Md. | | | | | | Baltimore | | 6111 Marietta Avenue | |
| 14 FATHER'S NAME | | | 15 MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| JOHN H. PERKINS | | | ELLEN LONG | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b SOCIAL SECURITY NO | | | 17 INFORMANT | | Address | |
| | | | 215-24-4892 | | | WIFE | | Same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Carcinomatosis, liver</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| <u>Acute tracheo-bronchitis</u> | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | HOUR A.M. Month Day Year | | | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d INJURY OCCURRED <input type="checkbox"/> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town County State | |
| | | | | | | | | | |
| 22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 10, 1968, to February 26, 1968, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on February 26, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | | 22c. DATE SIGNED | | | |
| Reynaldo Orjuela-Gomez, M.D. | | | | | | February 27, 1968 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | |
| | | | | | | 7620 York Rd., Towson, Md. 21204 | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| BURIAL | | 2/29/68 | | LOUON PK. | | BALTO MD | | | |
| 24 FUNERAL DIRECTOR | | | | | | 25a REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | |
| PAHEEMANN 6067 HARFORD RD | | | | | | MAR 4 1968 | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

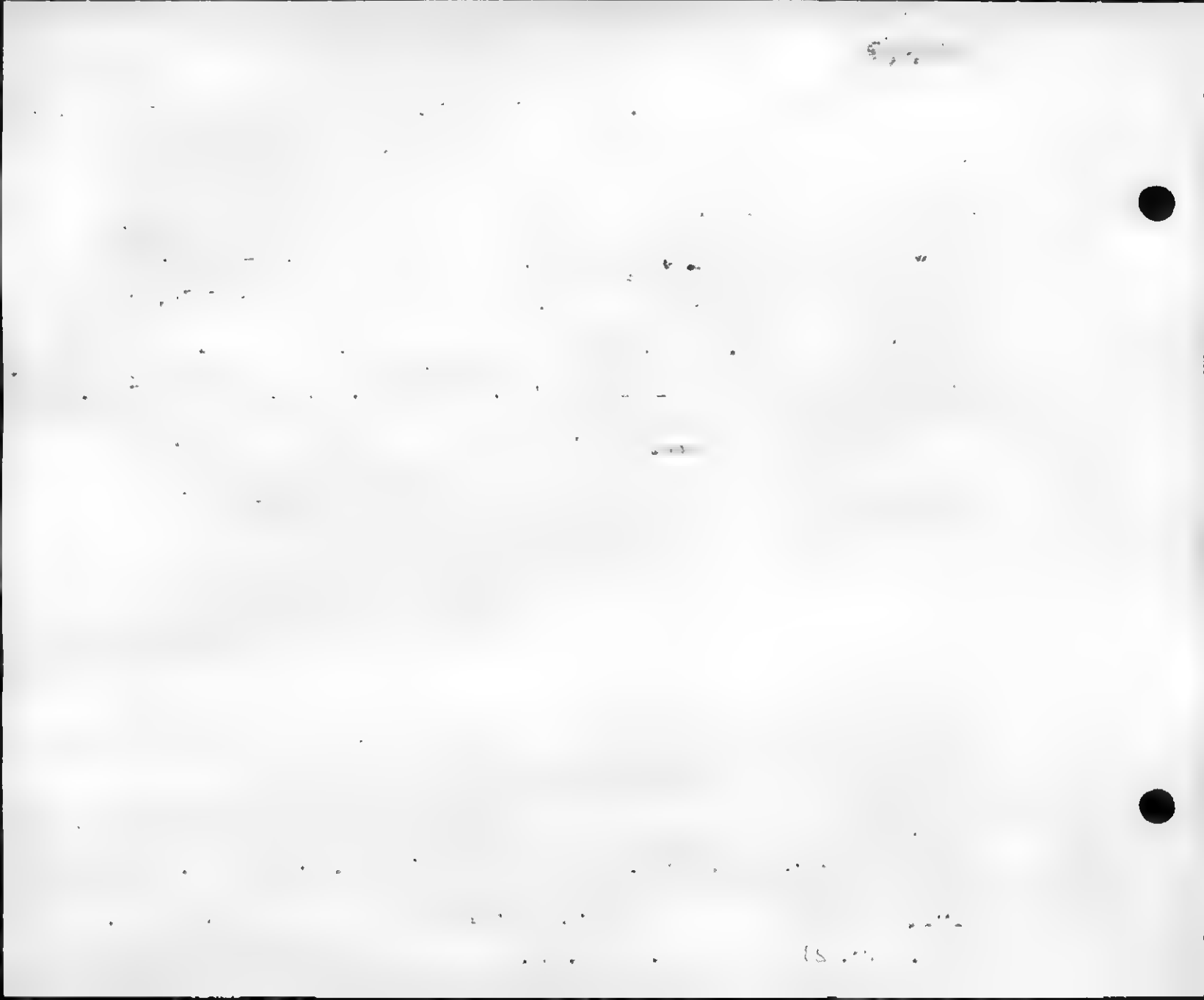
1

02313

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

2301

| | | | | | | | |
|---|---------|--|------------------|---|-------------------------------------|---|---|
| 1. DECEASED NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR |
| William | | H. | | PERRY | February 26, 1968 | | 7:40 AM |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | 7. IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN. |
| Male | White | | April 30, 1930 | | 37 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | |
| Maryland | | U.S.A. | | | | Baltimore, Md. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Towson | | ST. JOSEPH HOSPITAL | | Auto Salesman - Al Packer | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY L.I.M. 15? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| Maryland | | Baltimore | | Perry Hall | | 13e. STREET AND NUMBER
4347 Chapel Rd. | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First Middle Last |
| William | | H. | | Perry | Mavis M. | | ? |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT (Wife) | | Address | |
| Yes | | 212-30-4866 | | Mrs. Margorie J. Perry | | Perry Hall, Md.
4347 Chapel Rd. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (c) <u>Acute pulmonary edema</u> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic and hypertensive cardiovascular disease</u> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>2/26/</u> , 19 <u>68</u> , to <u>2/26/</u> , 19 <u>68</u> , that (X) (we) last saw the deceased alive on <u>2/26/</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Lawrence F. Misanik</u> | | | | | | 22c. DATE SIGNED
February 26, 1968 | |
| 22d. PHYSICIAN'S NAME (Type)
Lawrence F. Misanik, M.D. | | | | | | 22e. ADDRESS
7620 York Rd., Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | |
| Burial | | 3/1/68 | | Moreland Memorial Cemetery | | Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
John J. Duda, 2029 Hudson St. Balto. Md. | | | | 25a. REC'D BY REGISTRAR
DATE FEB 29 1968 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

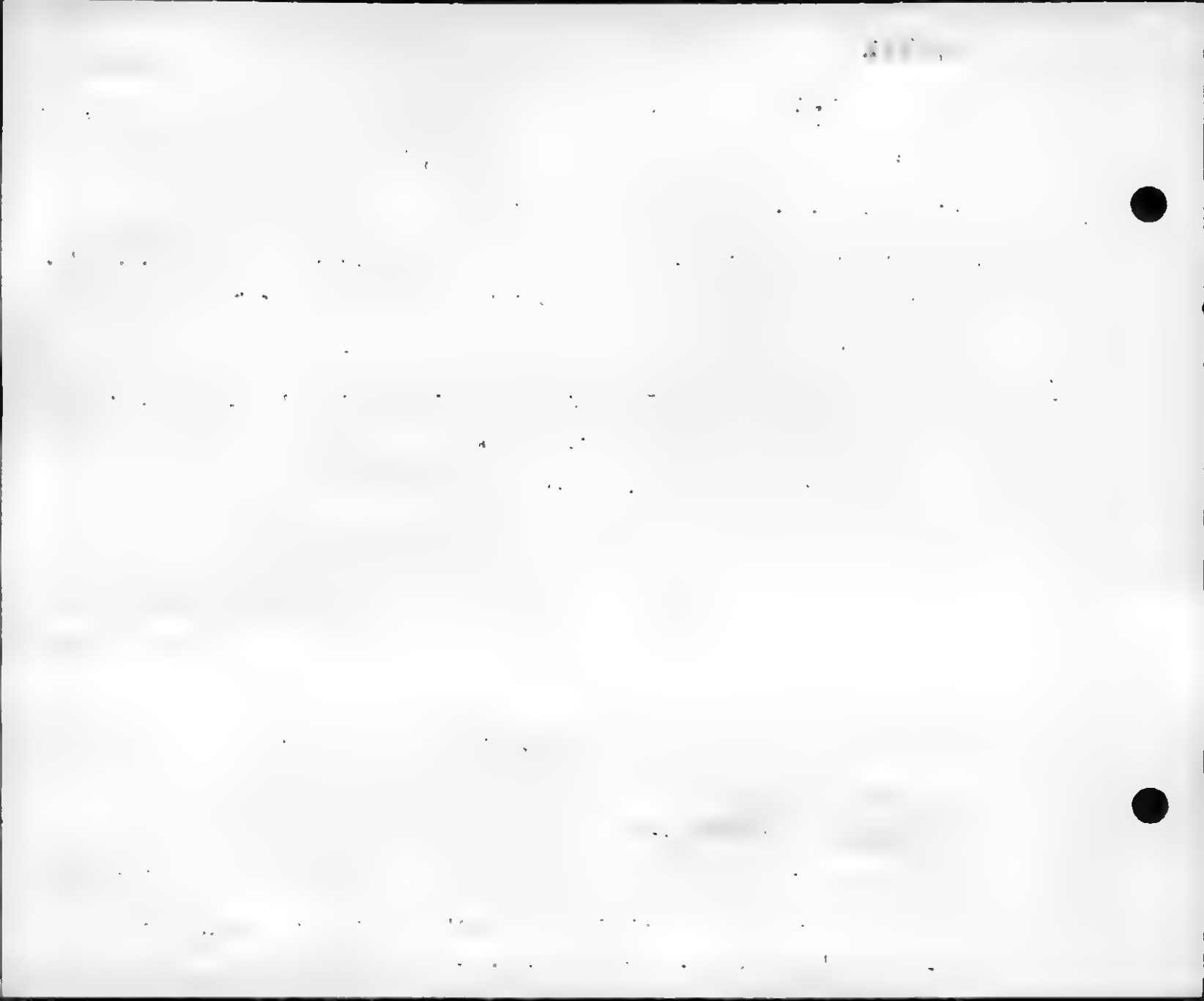


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

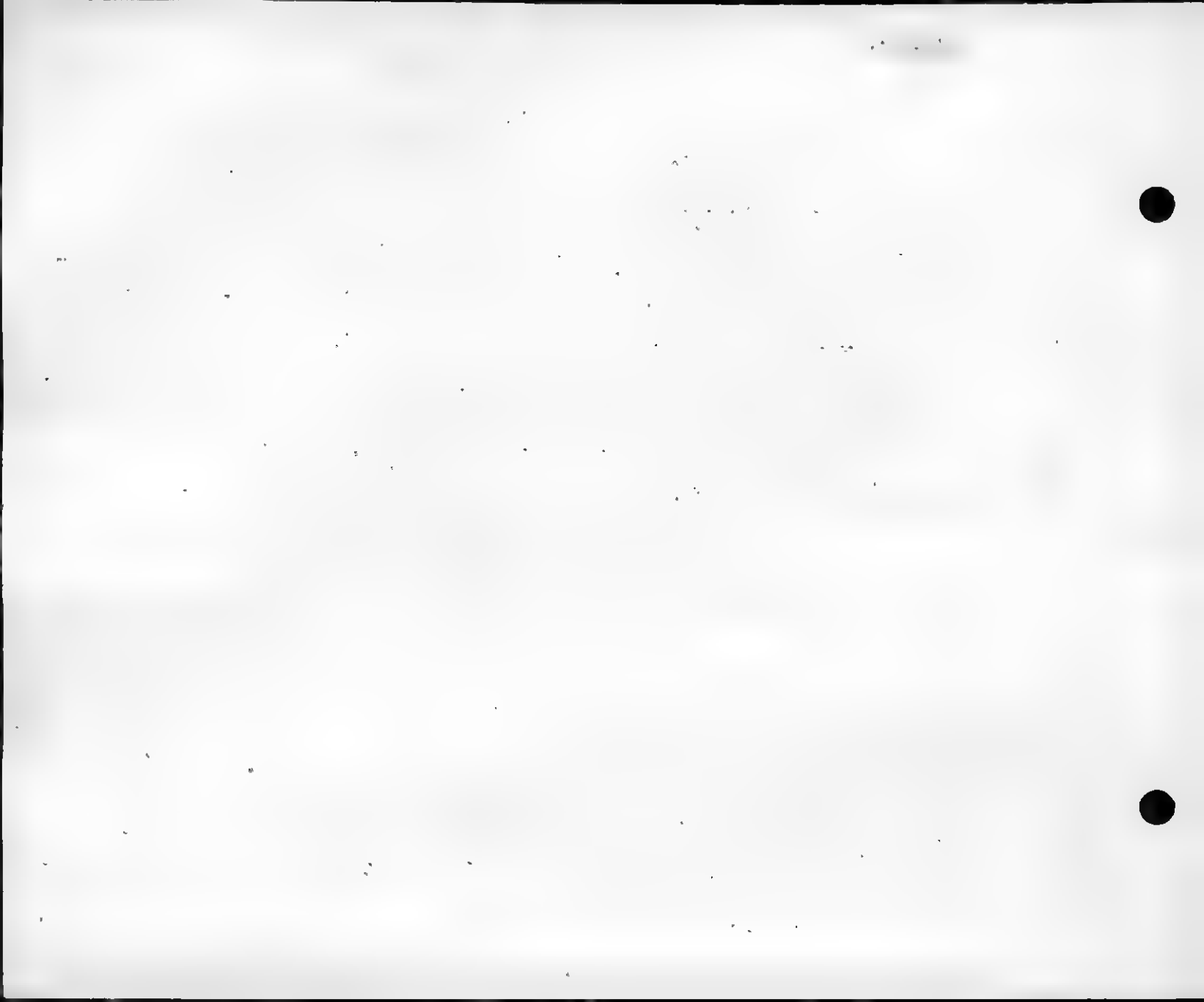
| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|---|--|--|---|--|--|-------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | |
| 1 DECEASED-NAME
(Type or print) | | | First
CLARA | | | Middle
R. | | | Last
PETREY | | | 2a DATE OF DEATH
2 Month 21 Day 68 Year | | | 2b HOUR
11:15 P | | |
| 3 SEX
Female | | | 4 RACE
Cau. | | | 5. DATE OF BIRTH
May 17, 1899 | | | 6 AGE (In years
lost birthday)
68 YRS | | | 7 UNDER 1 YEAR
MONTHS DAYS | | | IF UNDER 24 HRS
HOURS MIN. | | |
| 7a BIRTHPLACE (State or foreign
country)
Washington, D. C. | | | 7b CITIZEN OF WHAT COUNTRY?
USA | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 COUNTY OF DEATH
Baltimore Md | | | | | | | | |
| 10 CITY OR TOWN OF DEATH
Towson, Maryland | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Greater Balto. Med. Center | | | 12a USUAL OCCUPATION (Kind of work done
during most of working life, even if retired)
Secretary | | | 12b KIND OF BUSINESS OR
INDUSTRY
U.S. Gov't. | | | | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if
admission) STATE
Maryland | | | 13b COUNTY
Baltimore | | | 13c CITY OR TOWN
Baltimore | | | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e STREET AND NUMBER
87 Yorkway | | | | | |
| 14. FATHER'S NAME First Middle Last
Robert Studds | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Theresa Custin | | | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service)
no | | | 16b. SOCIAL SECURITY NO.
578-12-6776 | | | 17 INFORMANT
Richard H. Petrey, Son, 2468 Keyway, Baltimore, Md. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Severe lactic acidosis | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) Acute pyelonephritis | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Diabetes mellitus | | | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? Yes | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 2/21, 1968, to 2/21, 1968, that (I) (we) lost
saw the deceased alive on 2/21, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b SIGNATURE
John E. Adams | | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
Feb. 22, 1968 | | | | | | | | |
| 22d. PHYSICIAN'S
NAME (Type)
JOHN E. ADAMS, M.D. | | | | | | 22e. ADDRESS
Greater Baltimore Medical Center | | | | | | | | | | | |
| 23a BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | | 23b. DATE
2/26/68 | | | 23c NAME OF CEMETERY OR CREMATORY
Arlington National Cemetery | | | 23d LOCATION (City or Town) (County) (State)
Arlington Virginia | | | | | | | | |
| 24. FUNERAL DIRECTOR
Joseph Gawler's Sons, Inc. | | | | | | ADDRESS
Washington, D. C. | | | 25a REC'D BY REGISTRAR
DATE MAR 1 1968 | | | 25b. REGISTRAR'S SIGNATURE
Charles J. Jaffe | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MIDDLE | | | | | | | | | | LAST | | 2a. DATE OF DEATH | | 2b. HOUR | |
|---|--|--|--|--|--|---|--|--|--|-----------------|--|-------------------|--|--|--|
| 1. DECEASED NAME (Type or print) | | First | | Middle | | Last | | | | Month | | Day | | Year | |
| David | | Park | | Petrikin | | | | | | 2 | | 27 | | 1968 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (in years last birthday) | | 7. UNDER 1 YEAR | | 8. UNDER 24 HRS | | | | | |
| Male | | Whiten | | 8-1-1876 | | 91 YRS | | MONTHS | | DAYS | | HOURS | | MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | | | | |
| Johnstown Pa. | | U.S.A. | | | | Baltimore | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Linthigh | | 7435 Kenlea Ave | | Teacher | | Bethlehem C | | | | | | | | | |
| 13a. USLA RES DENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 3d. INSIDE CITY (Y.M.T.S?) | | 13e. STREET AND NUMBER | | | | | | | |
| Md. | | Balto. | | Linthigh | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 1435 Kenlea Avenue | | | | | | | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | First | | Middle | | Last | |
| Henry | | | | | | Petrikin | | Lucia | | | | | | Knowlton | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT | | Address | | | | | | | | | |
| No | | 146-07-7434 | | Mrs Lucille Slavik | | 7435 Kenlea Avenue 21236 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Antecerebral heart disease</u> | | | | | | | | | | | | | | 3 yrs | |
| 4129 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction</u> | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | |
| 41 | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med. col. examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No | | City or Town | | County | | State | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1962 to 2/27/68, that (I) (we) last saw the deceased alive on 2/23/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | | | | | | | | | |
| Conrad L. Richter | | | | | | 2/27/68 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | | | | | | | |
| Conrad L. Richter | | 3128 Haywood Rd | | Baltimore, Md | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | | | | | |
| Burial | | 2-29-1968 | | Grandview Cemetery | | Johnston | | | | Penn. | | | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Lassch Funeral Home | | 7401 Balcon Road | | 36 | | DATE MAR 4 1968 | | | | | | | | | |



FOR STATE
HEALTH DEPT.

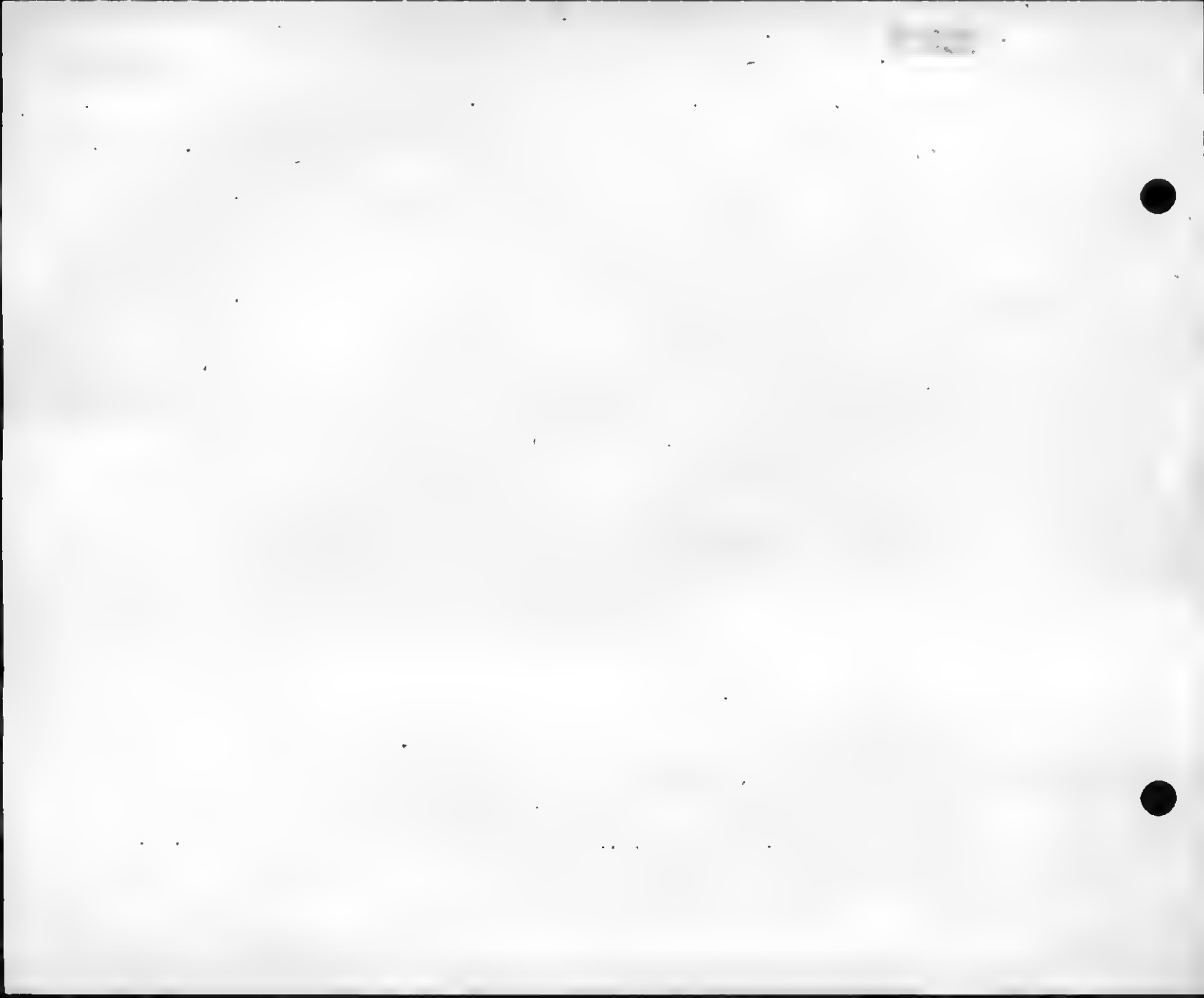
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

32316

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|--------|------------------------------|--|--|-------------------|---|--|--------------------------|---|--|----------|
| 1 DECEASED NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> 2/27 19 68 6:30 AM | | | 2b. HOUR | | |
| MARY CATHERINE PHILLIPS | | | | | | | | | | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (In years last birthday) | IF UNDER 1 YEAR | | F UNDER 24 HRS | | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR |
| female | white | Mar. 26, 1934 | 33 YRS | MONTHS | DAYS | HOURS | MIN. | February 27 19 68 | | | 8 A M |
| 7a. BIRTHPLACE (Store or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Maryland | | U.S.A. | | | | Baltimore | | | Md | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (if not a hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | |
| Dundalk | | | 4011 St. Monica Drive | | | At home | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Maryland | | | Baltimore | | | | | | 4011 St. Monica Drive | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO | | |
| James L. Morrissey | | | Edna Earl Fields | | | No | | | | | |
| 17. INFORMANT | | | ADDRESS | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| Paul F. Morrissey | | | 1304 First Road. 21220 | | | PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fatty Alteration of Liver | | | | | |
| | | | | | | DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | |
| | | | | | | DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | EXAMINER'S NAME (Type) | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED | | |
| Werner U. Spitz, M.D. | | | | | | ADDRESS (Street, city, town, or county) | | | 2.27.68 | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | | 3/2/68 | | | Meadow Ridge | | | Dorsey, Md. | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REG. STRAR | | | 25b. REG. STRAR'S SIGNATURE | | |
| Ulrich Funeral Home Dundalk, Md. | | | | | | DATE MAR 5 1968 | | | Charles Jones | | |



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

32317

2005

| | | | | | | | | |
|--|--|---|--------|--|-------------------------------------|---|-------------------|---|
| 1 DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR
P. M. | |
| Richard | | | | Pinkney | February 6 1968 | | 9:55 | |
| 3. SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (in years
last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS |
| male | | Negro | | 1876-12-9-1879 | | 88 YRS | | IF UNDER 24 HRS
HOURS MIN |
| 7a BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| Md. | | U. S. | | | | Baltimore | | Md. |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | 12a USUAL OCCUPATION (Kind of work done
during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR
INDUSTRY | | |
| Catonsville | | SPRING GROVE STATE HOSP. | | laborer | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution
admission) STATE | | 13b. COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER |
| Md. | | Pr. Geo. | | Cedar Hgts. | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 904 - 64th Avenue |
| 14 FATHER'S NAME
First Middle Last | | 15 MOTHER'S MAIDEN NAME
First Middle Last | | | | | | |
| Robert Pinkney | | Laura Brooks | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service) | | 16b SOCIAL SECURITY NO | | 17. INFORMANT | | Address | | |
| | | 219-54-3272 | | Records: SPRING GROVE STATE HOSPITAL | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction, Acute, death, | | | | | | | | 3 days |
| DUE TO, OR AS A CONSEQUENCE OF vascular ht. dis. with Arteriosclerotic, Hypertensio- | | | | | | | | 3 years. |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis, generalized, since 20 yrs. | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic Arteriosclerosis with azotemia; Subdural Hematoma, etc. | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | |
| | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY
(AT HOME, FARM, STREET, FACTORY)
OFFICE BUILDING, ETC. | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| | | | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from Oct. 27, 1965, to Feb. 6, 1968, that (we) last saw the deceased alive on Feb. 6, 1968, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | |
| 22b SIGNATURE
Anthony J. Young, M.D. | | | | | | 22c DATE SIGNED
2-7-68 | | |
| 22d. PHYSICIAN'S NAME (Type)
Anthony J. Young, M.D. | | | | | | 22e. ADDRESS
SPRING GROVE STATE HOSPITAL
Baltimore, Maryland 21228 | | |
| 23a BURIAL CREMATION
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | 2-14-68 | | Brooks Church Cem. | | Nottingham Pr. Geo. Md. | | |
| 24 FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | |
| Martell Adams | | Aguasco, Md. | | FEB 16 1968 | | Charles Jones | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

740.4. Kirby. Box
21 or 22. 1916
or 6. Co.

re 11

21

21

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02318

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02346

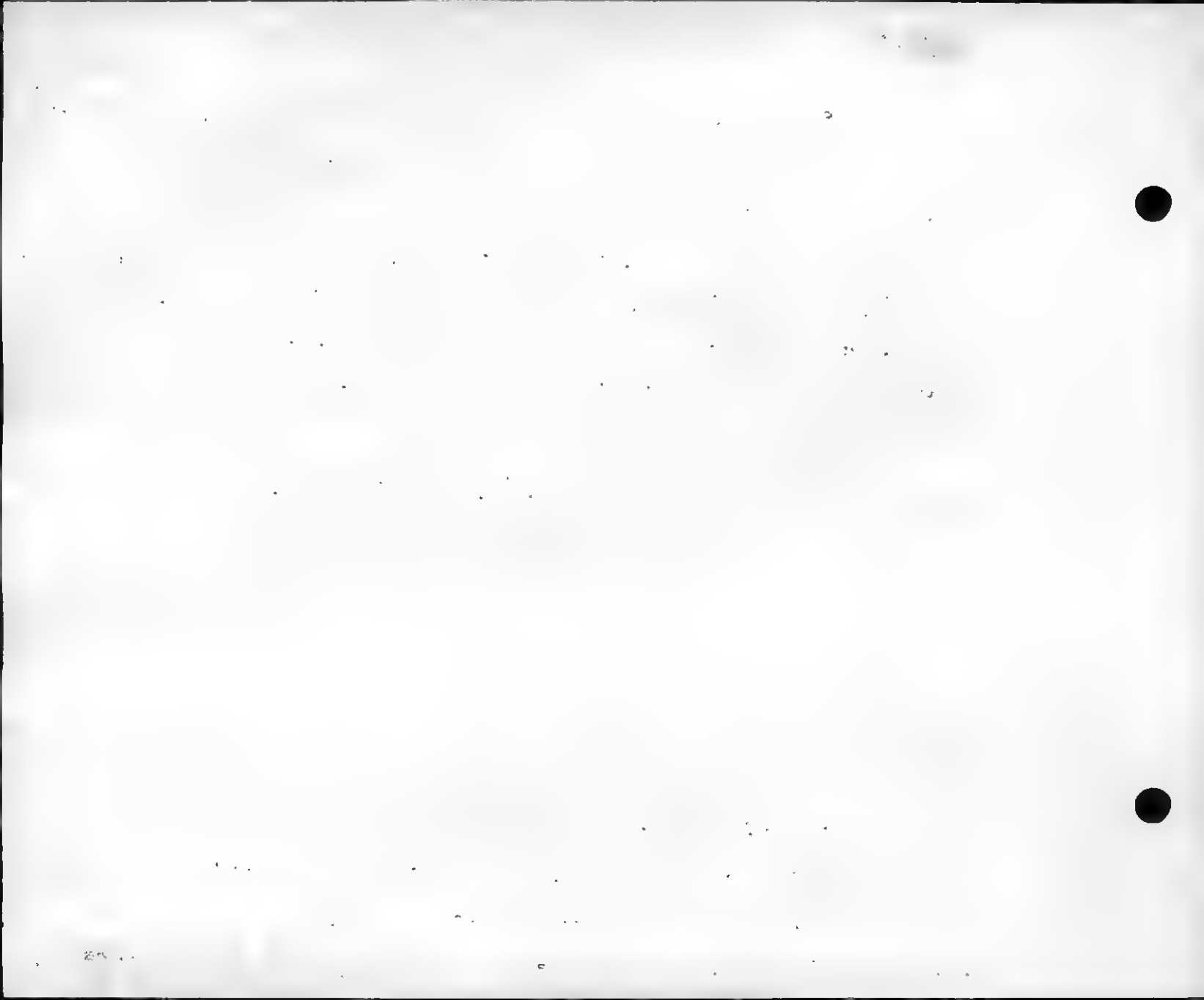
| | | | | | |
|---|--|--|--|---|----------------------------|
| 1. DECEASED-NAME
(Type or print) Virginia First B. Middle Poissal Last | | | 2a. DATE OF DEATH
Month Feb Day 22 Year 1968 | | 2b. HOUR
9:45p M |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
March 30, 1916 | |
| 7a. BIRTHPLACE (State or foreign country)
Balto. Md | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
Catonsville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Shangri-La Nursing Home | | 12a. USUA. OCCUPATION (Kind of work done during most of work ng life, even if ret red)
Secretary | |
| 13a. USUA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE
Maryland | | 13b. COUNTY
Balto. | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME First Clarence Middle Billmyer Last Edith | | 15. MOTHER'S MAIDEN NAME First Bain Middle Bain Last Bain | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) no (1 yes give war or dates of service) | |
| 16b. SOCIAL SECURITY NO
712-03-3233 | | 17. INFORMANT
George D. Poissal | | 17. ADDRESS
3401 Rockdale Court Balto. Md 21207 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
174x IMMEDIATE CAUSE (a) C.A. of Breast
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Metastases
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-2- , 1968, to 2-22- , 1968, that (I) (we) last saw the deceased alive on 2-22- , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Cesar Valle Caverio | | | | 22c. DATE SIGNED
2-24-68 | |
| 22d. PHYSICIAN'S NAME (Type)
Dr. Cesar Valle Caverio | | | | 22e. ADDRESS
8629 Liberty Rd Randallstown, Md 21133 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
2/26/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Lakeview Memorial | |
| 23d. LOCATION (City or Town)
Liberty Rd Carroll Co. Md | | 23e. LOCATION (County)
Carroll Co. | | 23f. LOCATION (State)
Md | |
| 24. FUNERAL DIRECTOR
Virgil Byers | | 24a. ADDRESS
8728 Liberty Rd Lanesville, Md | | 25a. REC'D BY REGISTRAR
FEB 27 1968 | |
| 25b. REGISTRAR'S SIGNATURE
[Signature] | | 25c. REGISTRAR'S SIGNATURE
[Signature] | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>32319</div> <div> <div>MD</div> <div> <div>1</div> <div>2</div> </div> </div> <div> <div> <div>1</div> <div>2</div> </div> <div> <div>1</div> <div>2</div> </div> </div> | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|--|--|
| <div> <div> <div>1</div> <div>2</div> </div> <div> <div>1</div> <div>2</div> </div> </div> | | | | | | | | | | | |
| 1. DECEASED NAME
(Type or print) GEORGE POPP | | | | | | 2a. DATE OF DEATH
Month February Day 11 Year 1968 | | | 2b. HOUR 2:45 MIN PM | | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH
February 17 1873 | | | 6. AGE (In years last birthday)
94 | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | IF UNDER 24 HRS
HOURS 0 MIN 0 |
| 7a. BIRTHPLACE (State or foreign country)
Md | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Glen Arm Rd. | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Ret. Guard | | 12b. KIND OF BUSINESS OR INDUSTRY
Balto City | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE
Md | | | | 13b. COUNTY
Balto | | 13c. CITY OR TOWN
Glen Arm Rd. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
Glen Arm Rd. | |
| 14. FATHER'S NAME
First John Middle Popp Last Popp | | | | 15. MOTHER'S MAIDEN NAME
First Rachel Middle Green Last Green | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown No (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO.
217-48-1628 | | 17. INFORMANT
Family Records | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
1104
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, (which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. _____ Month _____ Day _____ Year _____
P.M. _____ 19 _____ | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION
Street or R.F.D. No _____ City or Town _____ County _____ State _____ | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Henry L. McCorkle M.D. | | | | | | DEGREE _____ ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
2-13-68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Henry L. McCorkle M.D. | | | | | | 22e. ADDRESS
Jacksonville, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
2-13-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Balto Co Md. | | | | | |
| 24. FUNERAL DIRECTOR
C.F. EVANS & SON 8802 Harford road | | | | | | 25a. REC'D BY REGISTRAR
DATE FEB 15 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |



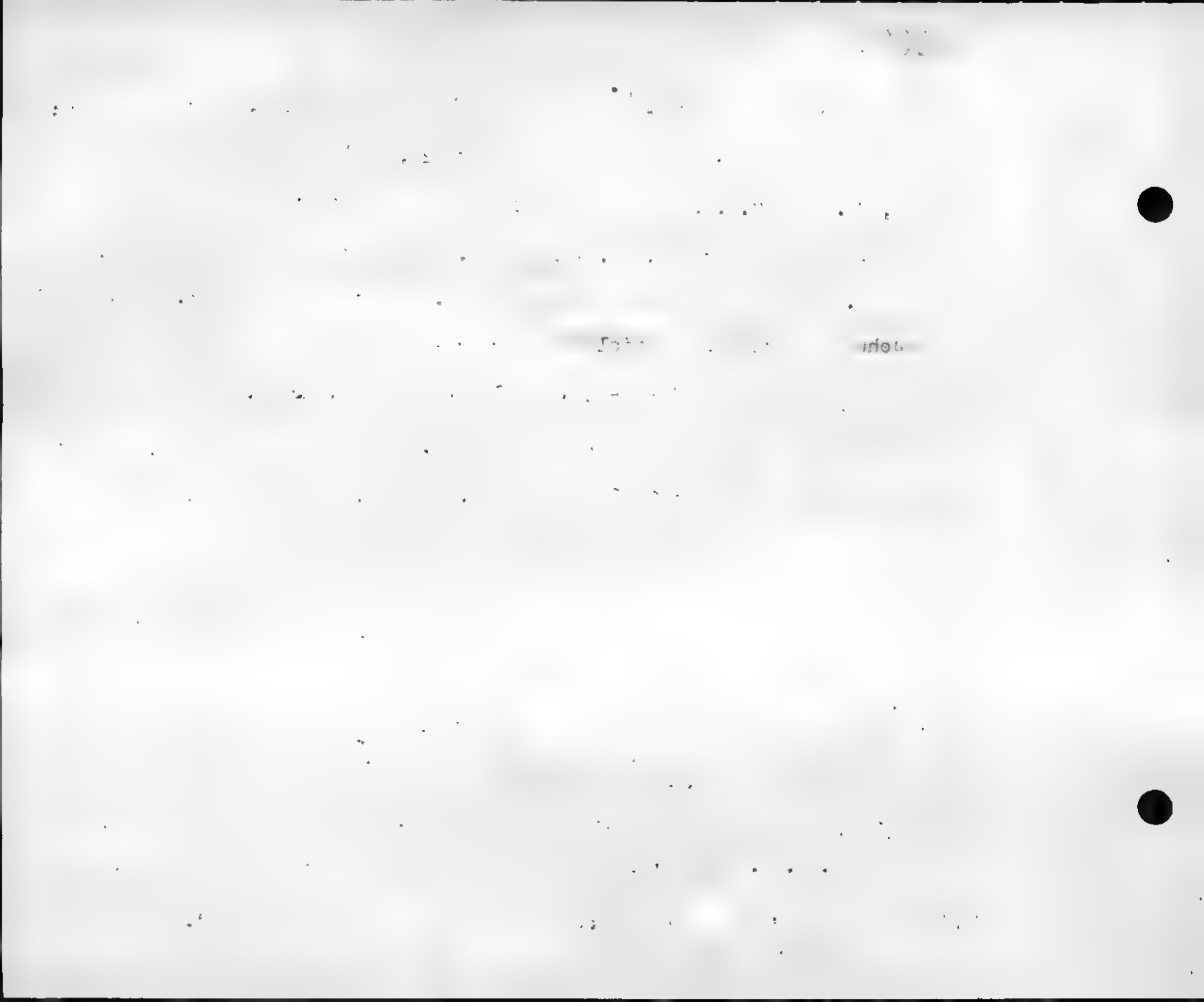
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 1A (4)
30M REV. 1/68

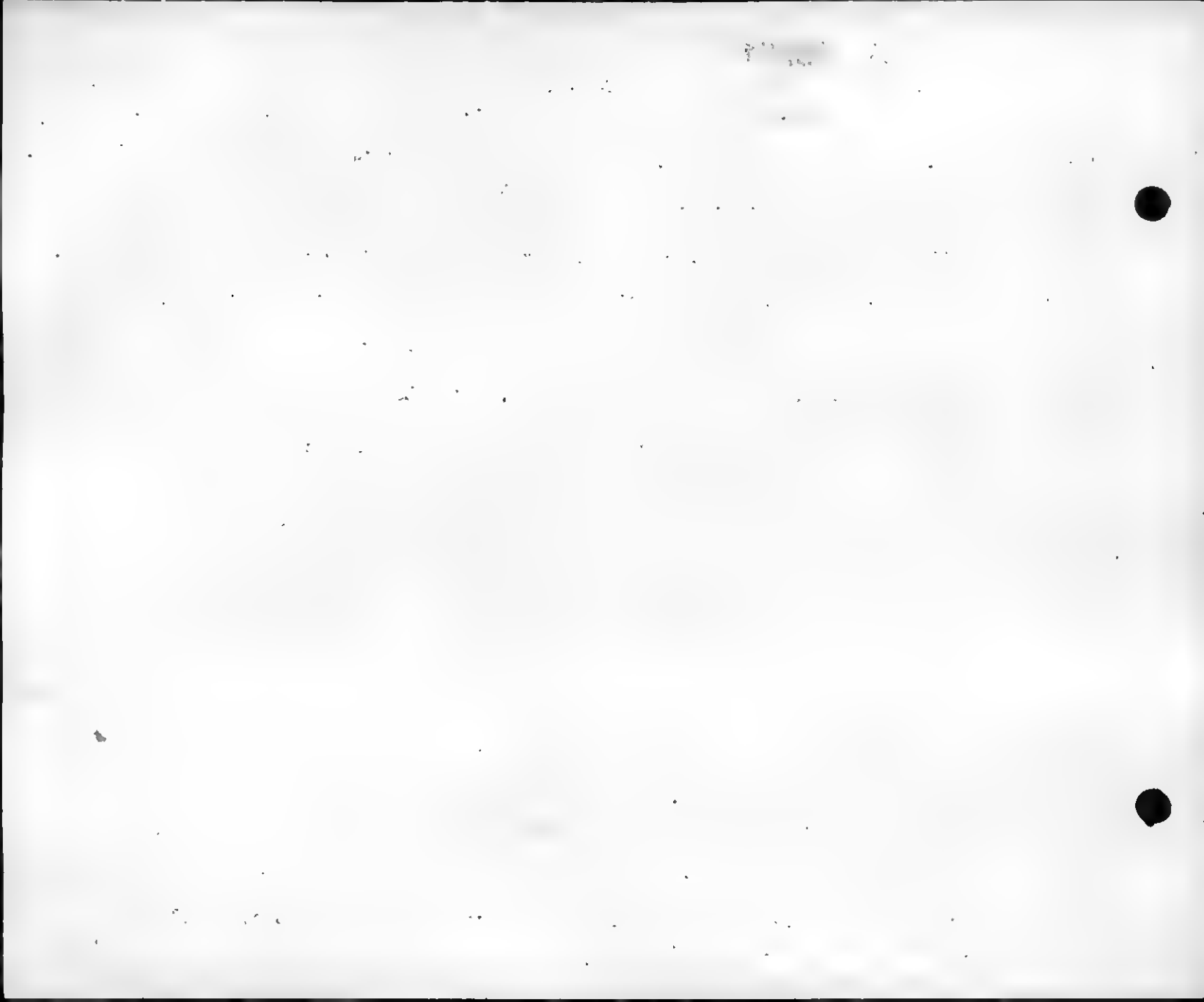
| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|--|--|---|--|-----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Mary Teresa Pospisil | | | | | | February 10 1968 | | 9:15 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | |
| female | | white | | June 28, 1884 | | 83 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Baltimore, Md. | | U.S.A. | | | | Baltimore | | Md | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Bowleys Quarters | | | Box 537, Rt. 15, Bay Dr. | | | housewife | | none | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET AND NUMBER | |
| Md. | | | Baltimore | | | Bowleys Qrts. | | Box 537, Rt. 15, Bay Drive | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| John Priol | | | Frances Velnovsky | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | |
| no | | | 213-48-0495 | | | Albert Pospisil, above, son | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL FAILURE</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>FEB 1 1968</u> |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> | | | | | | | | | ? |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| NONE | | NONE | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | NONE | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, fully filled on examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B) | | | | | |
| | | HOUR A.M. Month Day Year | | NONE | | | | | |
| 21d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | County State |
| NONE | | NONE | | NONE | | NONE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>FEB 2</u> , 19 <u>68</u> , to <u>FEB 10</u> , 19 <u>68</u> , that (I) (was) last saw the deceased alive on <u>FEB 7</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>E. A. Schimunek</u> M.D. DEGREE | | | | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>2-11-68</u> | |
| 22d. PHYSICIAN'S NAME (Type) <u>Dr. E. A. Schimunek</u> | | | | | | 22e. ADDRESS <u>842 S. EAST AVE BALTO. MD 21224</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 2/13/68 | | Holy Redeemer Cemetery | | Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR <u>Schimunek Funeral Home</u> ADDRESS <u>3331 Brehms Lane #13</u> | | | | | | 25a. REC'D BY REGISTRAR DATE <u>FEB 11</u> | | 25b. REGISTRAR'S SIGNATURE | |

MEDICAL CERTIFICATION



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | | | | | | | | | | |
|--|--|----------------------|--|-----------------------------------|---|---|--|---|---|---|---|--|---|--|-------------------------|--|--|--|--|
| Item 6, Film G398
3/4/68 ap 22321 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| DECEASED-NAME (Type or print) First JOHN Middle STANLEY Last Probst | | | | | | | | | | 2a. DATE OF DEATH Month 2 Day 25 Year 68 | | | | | 2b. HOUR 9:35p M | | | | |
| 3 SEX Male | | 4. RACE White | | 5. DATE OF BIRTH 6/26/1896 | | | | | 6 AGE (n years last birthday) 72 77 YRS. | | IF UNDER 1 YEAR MONTHS 72 DAYS 77 | | IF UNDER 24 HRS. HOURS 72 MIN. 77 | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) Illinois | | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 COUNTY OF DEATH Baltimore Md. | | | | | | | | | | |
| 10 CITY OR TOWN OF DEATH Baltimore | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto., Med. Center | | | 12a. USUAL OCCUPATION (Kind of work done during most of work-life, even if retired) Adv. Owner | | | 12b. KIND OF BUSINESS OR INDUSTRY ADV. | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md. | | | 13b. COUNTY Baltimore | | | 13c. CITY OR TOWN Ruxton | | 13d. INSIDE CITY LIM TS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 1604 Ruxton Ct. | | | | | | | | | |
| 14 FATHER'S NAME First Nicholas Middle Prodst Last Prodst | | | | | 15 MOTHER'S MAIDEN NAME First Joanna Middle Gleason Last Gleason | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) Yes W. W. One | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address Mrs. Helen Louise Probst, Same as #13 | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
+129
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/18 , 19 68 , to 2/25 , 19 68 , that (I) (we) last saw the deceased alive on 2/25 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE R. Breiteneker | | | DEGREE | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 2/26/68 | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) R. Breiteneker, M.D. | | | 22e. ADDRESS 6701 N. Charles Street | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE Feb. 28, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore National | | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson, Md. 21204 | | | | | | 25a. REC'D BY REGISTRAR FEB 29 1968 | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | |

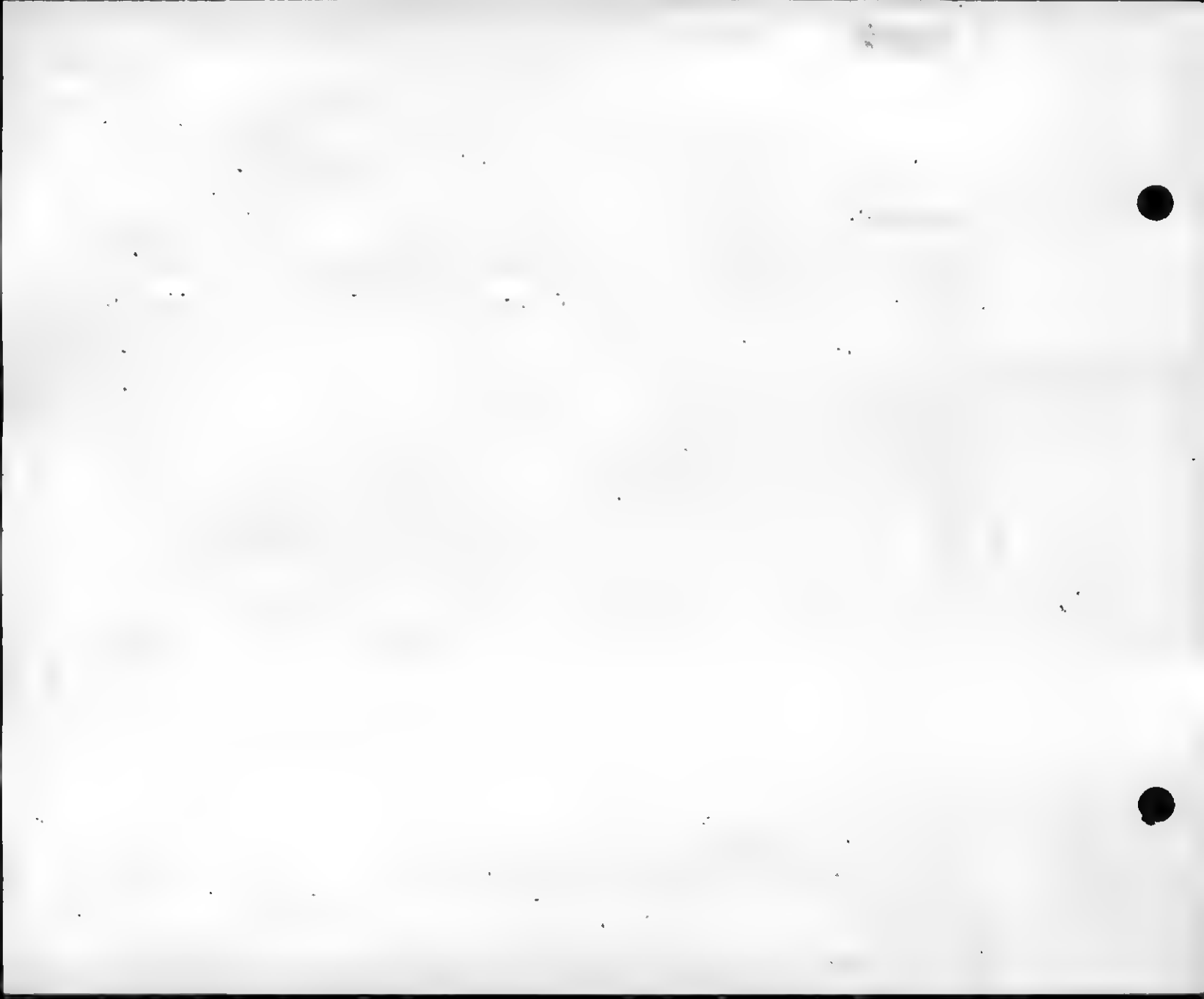


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

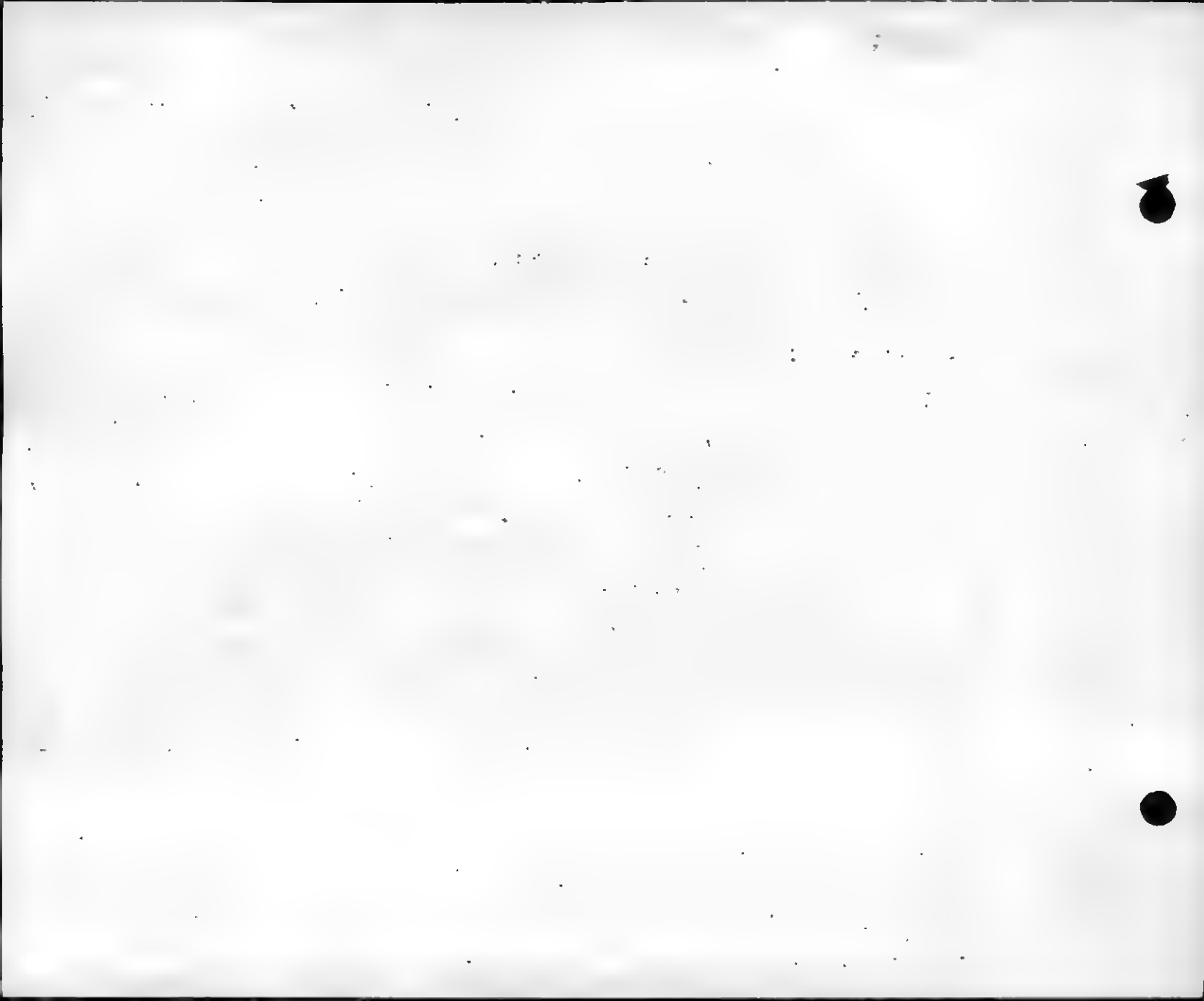
| <div style="display: flex; justify-content: space-between;"> 02322 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02310 </div> | | | | | | | | | | | | | | | | |
|---|--|---|---|---|--|--|--|--|---|--|--|---|--|--|-------------------|--|
| 1 DECEASED-NAME
(Type or print) | | | First Gladys | | | Middle A. | | | Last PUKALL | | | 2a DATE OF DEATH
Month Day Year
February 13, 1968 | | | 2b HOUR
8:05AM | |
| 3 SEX
Female | | | 4 RACE
White | | | 5 DATE OF BIRTH
March 26, 1914 | | | 6 AGE (In years last birthday)
53 YRS | | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | | |
| 7a BIRTHPLACE (State or foreign country)
Pennsylvania | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 COUNTY OF DEATH
Baltimore, Md | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
ST. JOSEPH HOSPITAL | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Homemaker | | | 12b KIND OF BUSINESS OR INDUSTRY
At Home | | | | | | | |
| 13a USUA. RES DENCE (Where deceased lived, if institution admission) STATE
Maryland | | | 13b. COUNTY
Baltimore | | | 13c. CITY OR TOWN
Baltimore | | | 13d. INSIDE CITY LIM TSY
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e STREET AND NUMBER
3116 Willoughby Rd. | | | | |
| 14. FATHER'S NAME
First Samuel J Middle Schubert Last | | | 15. MOTHER'S MAIDEN NAME
First Mary Ellen Middle Hainworth Last | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT
William A. Pukall | | | Address
Same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cerebral hemorrhage
4:10 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hypertension
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | | |
| 21d INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f LOCATION Street or R.F.D. No City or Town County State | | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from 2/12/1968, to 2/13/1968, that (X) (we) last saw the deceased alive on 2/13/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Gualberto Gokim, Jr., M.D. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | | | | | | | | 22c. DATE SIGNED
February 13, 1968 | | |
| 22d PHYSICIAN'S NAME (Type) | | Gualberto G. Gokim Jr. | | | | 22e ADDRESS
7620 York Rd., Towson, Md. 21204 | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE
2-16-1968 | | 23c NAME OF CEMETERY OR CREMATORY
Garden of Faith | | | | 23d LOCATION (City or Town) (County) (State)
Baltimore Md | | | | | | | | |
| 24 FUNERAL DIRECTOR
Charles T. Evans, Jr. | | ADDRESS
8802 Harford Rd | | | | 25a REC'D BY REGISTRAR
DATE FEB 14 1968 | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

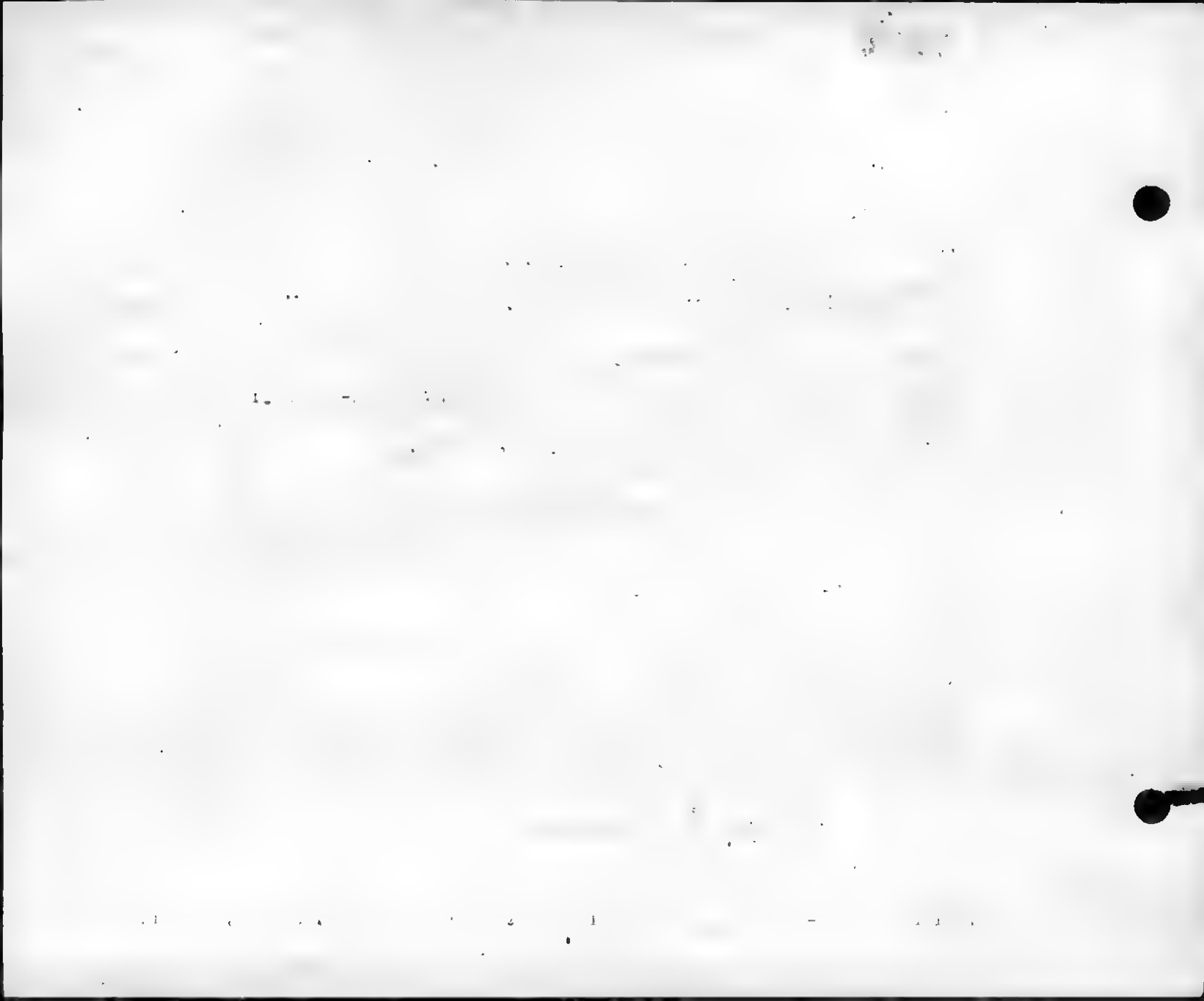
| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | |
|---|--|--------|--|---|--|---|--------------------------------|---|--|-----------------------|-----------------|----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1 DECEASED NAME (Type or print) | | | First Middle Last | | | 2a DATE OF DEATH | | | 2b HOUR | | | | |
| MARTY M. RADWITCH | | | | | | FEB Month 5 Day 68 Year | | | 3:00 P.M. | | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | | 6 AGE (In years lost birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| F | | W | | 1/10/92 | | | 76 YRS. | | MONTHS DAYS | | HOURS MIN. | | |
| 7a BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | Md. | |
| MD | | | USA | | | | | | BALTO | | | | |
| 10 CITY OR TOWN OF DEATH | | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | | 12b KIND OF BUSINESS OR INDUSTRY | |
| DUNDALK | | | | 7001 DUNMANWAY | | | | | | | | | |
| 13a USUAL RESIDENCE (Where deceased was, if institution. Residence before admission) STATE | | | 13b COUNTY | | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER | | | |
| MD | | | BALTO | | | DUNDALK | | | | 7001 DUNMANWAY | | | |
| 14. FATHER'S NAME First Middle Last | | | | 15 MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | |
| WILLIAM STUBBS | | | | ? | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | | 16b. SOCIAL SECURITY NO | | | | 17 INFORMANT | | | | Address | |
| No | | | | | | | | ANN ZINKAND | | | | ABOVE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. <u>OCIA of Liver</u> DUE TO: <u>AS A CONSEQUENCE OF</u> (b) <u>Diabetes Mellitus</u> (c) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>12/1/67</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 mos</u> <u>2 yrs</u> <u>5 yrs</u> | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>A-S-C-V-N disease</u> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| | | | | | | Feb 1968 | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 1968, to Feb 5, 1968, that (I) (we) last saw the deceased alive on Feb 5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | |
| M. B. DAVIS MD | | | 2/16/68 | | | M. B. DAVIS MD | | | 6800 MORNING GLORY - NEWTOWN | | | | |
| 23a. BURIAL CREMATION REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| BURIAL | | | 2/8/68 | | | DAK LAWN | | | BALTO. MD. | | | | |
| 24. FUNERAL DIRECTOR | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| J. G. CONNELLY SONS | | | DATE FEB 8 1968 | | | MICHAEL J. JUDGE | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|--|--|---|--|--|------------------------------|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME
(Type or print) | | | First
RUTH | | | Middle
EVELYN | | | Last
RAUSCH | | | 2a. DATE OF DEATH
Month 2 Day 14 Year 68 | | | 2b. HOUR
12:45 PM | | |
| 3. SEX
Female | | | 4. RACE
Caucasian | | | 5. DATE OF BIRTH
4-27-1892 | | | 6. AGE (In years
last birthday)
75 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | | IF UNDER 24 HRS
HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign
country)
Baltimore | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Baltimore | | | Md | | | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Greater Balto. Medical Center | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if
admission) STATE
Maryland | | | 13b. COUNTY
Baltimore | | | 13c. CITY OR TOWN
Balto. | | | 3d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER
6501 Liberty Road | | | | | |
| 14. FATHER'S NAME
First Middle Last
Jacob Mehrling | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Jordan | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
NO | | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | | 17. INFORMANT
Address
Harry A. Rausch-6501 Liberty Road | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1 DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Multiple pulmonary infarcts
450 X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Carcinoma, right breast | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH?
YES | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION
Street or R.F.D. No City or Town County State | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/6, 1968, to 2/14 1968, that (I) (we) last
saw the deceased alive on 2/14 1968, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Rudiger Breiteneker | | | DEGREE
M.D. | | | ATTENDING
PHYS <input type="checkbox"/> MED
DIRECTOR <input type="checkbox"/> STAFF
PHYS <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
2/14/68 | | | | | | | | |
| 22d. PHYSICIAN'S
NAME (Type)
Rudiger Breiteneker, M. D. | | | 22e. ADDRESS
Greater Baltimore Medical Center | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | | 23b. DATE
2-17-68 | | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | | | | | | | |
| 24. FUNERAL DIRECTOR
Charles Judge | | | 25a. REC'D BY REGISTRAR
DATE FEB 20 1968 | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | | | | |



FOR STATE HEALTH DEPT.

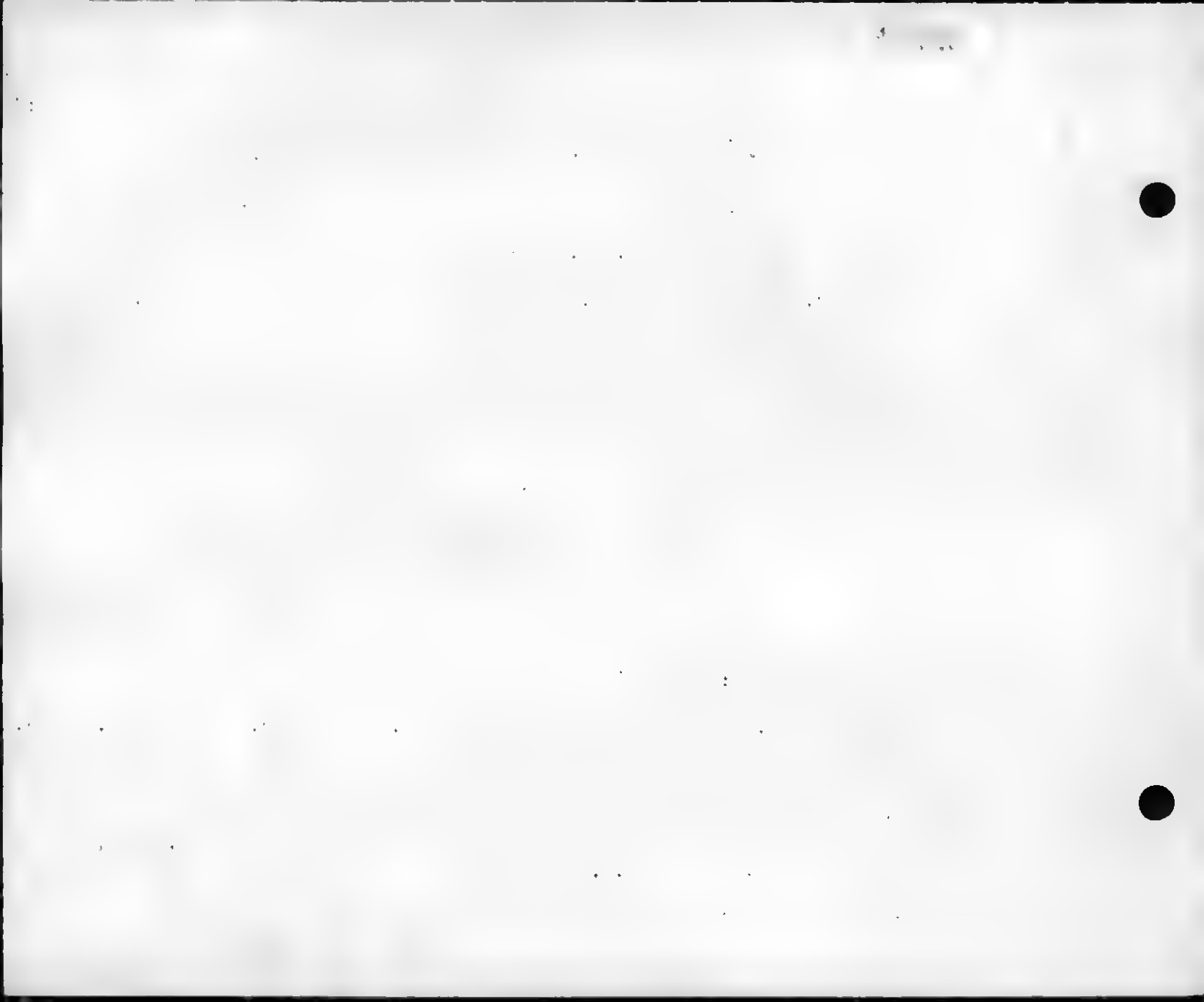
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PMS Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12325

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | |
|--|--|--------|-------------------|---|--|--|--|---|----------------|-----------------|--|---|--|--|--|----------------------------------|--|--|--|
| 1 DECEASED NAME
(Type or Print) | | | First Middle Last | | | 2a DATE KNOWN OF DEATH | | | Month Day Year | | | 2b HOUR | | | | | | | |
| IRMA | | | LOUISE | | | RAY | | | 2 25 19 68 | | | 1:30 | | | | | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (in years last birthday) | | 7 UNDER YEAR | | IF UNDER 24 HRS | | 2c DATE PRONOUNCED DEAD | | 2d HOUR | | | | | |
| Female | | White | | 3/29/34 | | 34 YRS | | MONTHS | | DAYS | | Month Day Year | | 19 68 1:30 | | | | | |
| 7a BIRTHPLACE (State or foreign country) | | | | 7b CITIZEN OF WHAT COUNTRY? | | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH | | | | | | | |
| VA. | | | | U.S.A. | | | | | | | | Balto. Md. | | | | | | | |
| 10 CITY OR TOWN OF DEATH | | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | | | North Pt. Rd. Discount Liquors | | | | | | | | | | | | PAPER | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Res. den. before admission) STATE | | | | 13b COUNTY | | | | 13c CITY OR TOWN | | | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e STREET AND NUMBER | | | |
| Md. | | | | Balto. | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 313 Capital Ct. | | | |
| 14 FATHER'S NAME | | | | | | 15 MOTHER'S MAIDEN NAME | | | | | | | | | | | | | |
| First Middle Last | | | | | | First Middle Last | | | | | | | | | | | | | |
| ROBERT H. DONAHUE | | | | | | MARY HODEES | | | | | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | | | 16b SOCIAL SECURITY NO | | | | | | 17 INFORMANT ADDRESS | | | | | | | |
| no | | | | | | — | | | | | | JACOB RAY ABOVE | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gunshot wound of the chest and back | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20 AUTOPSY? | | | | | | | |
| | | | | | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | 21b TIME OF INJURY Month Day Year HOUR A.M. | | | | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) | | | | | | | |
| | | | | | | 12:31 2 25 19 68 | | | | | | Subject was shot several times | | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | | | | 21e PLACE OF INJURY (At home, farm, street factory, office building, etc.) | | | | | | 21f LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| Sr. | | | | | | North Pt. Rd. | | | | | | Balto. Balto. Md. | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect an <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | CHIEF MEDICAL EXAMINER | | | | | | 22b DATE SIGNED | | | | | | | |
| EXAMINER'S NAME (Type) | | | | | | ASSISTANT MEDICAL EXAMINER | | | | | | DEPUTY MEDICAL EXAMINER | | | | | | | |
| Edward F. Wilson, M.D. | | | | | | | | | | | | Feb. 25, 1968 | | | | | | | |
| 23a BURIAL, CREMATION REMOVAL (Specify) | | | | | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | | | 23d LOCATION (City or Town) (County) (State) | | | | | | | |
| BURIAL | | | | | | 2/28/68 | | GARDENS OF FAITH | | | | BALTO. MD | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | ADDRESS | | | | | | 25a REC'D BY REGISTRAR | | | | 25b REGISTRAR'S SIGNATURE | | | |
| J.E. CONNELLY | | | | | | 300 MACE | | | | | | DATE Feb. 28 1968 | | | | Charles Jones | | | |



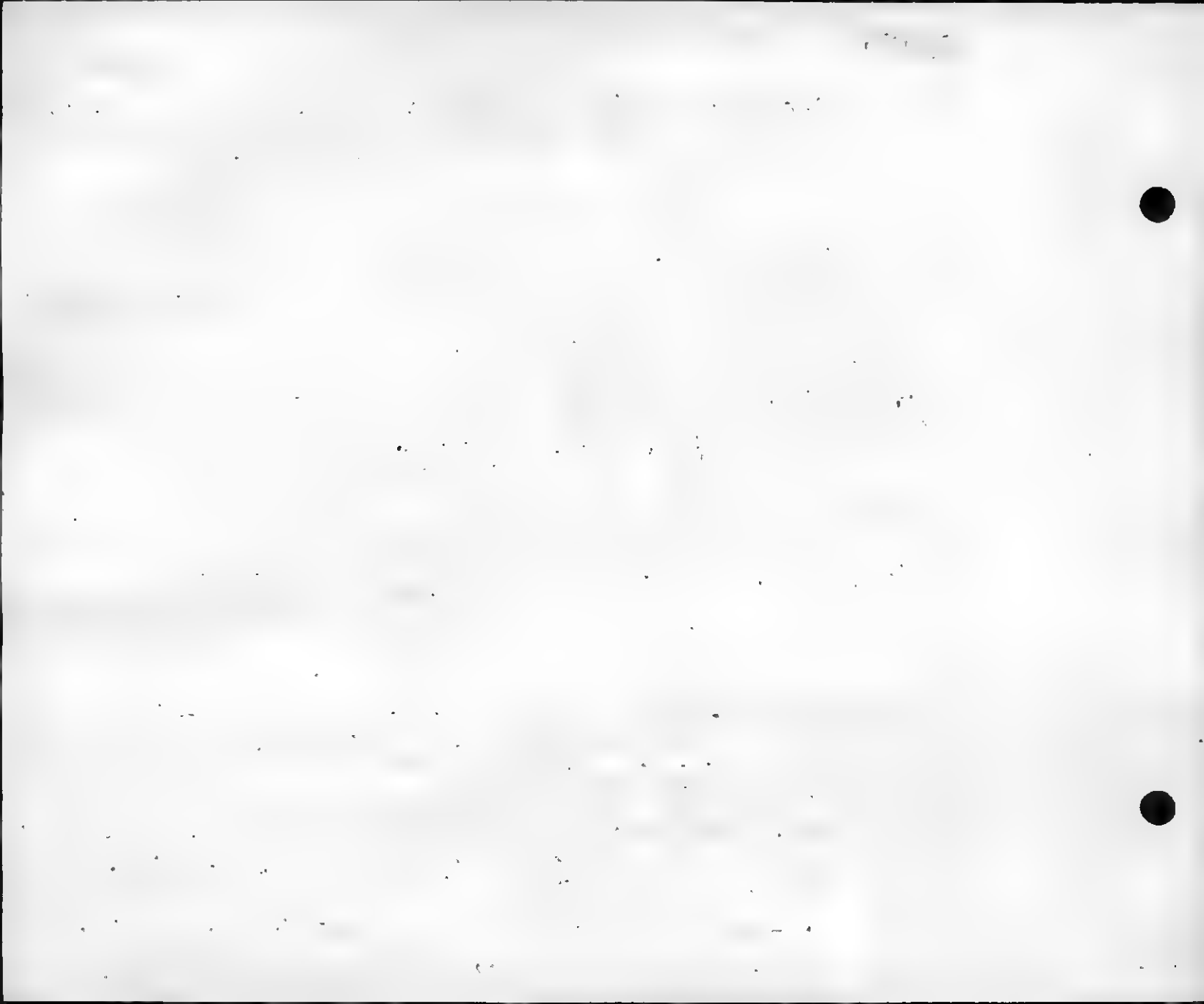
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 2 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
OM REV 1/68

| <div> <div>22326</div> <div> <div>MD</div> <div>22326</div> </div> </div> <div> <div>MD</div> <div>22326</div> </div> | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|----------------------------|--|--|--|
| 1 DECEASED-NAME (Type or print) | | | | | | 2a DATE OF DEATH | | | 2b HOUR | | |
| <div> <div>First</div> <div>Middle</div> <div>Last</div> </div> <div>CHARLES E READ</div> | | | | | | <div> <div>Month</div> <div>Day</div> <div>Year</div> </div> <div>2 5 68</div> | | | <div> <div>Hour</div> <div>Minute</div> </div> <div>12 40 PM</div> | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | 7. UNDER 1 YEAR | | 7. UNDER 24 HRS | |
| M | | W | | 7-11-93 | | 74 YRS | | MONTHS | | DAYS | |
| 7a BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| MD | | USA | | | | BALTO. County Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Catonville | | Summit Hs. H. Electrum | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| MD | | | | BALTO. | | YES | | 3225 Leach Street | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| William | | | | Read | | | | Gruenewald | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT Address | | | | | |
| YES | | | | 219-10-6090 | | WIFE - Same as above | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| <div> <div>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</div> <div>1930</div> </div> <div> <div>Metastatic Carcinoma to Brain</div> <div>Primary site unknown</div> </div> | | | | | | | | | | ? | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| Ascid | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | YES | | NO | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC) | | 21f. LOCATION | | Street or R.F.D. No | | City or Town | | County State | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-4-68 to 2-5-68, that (I) (we) last saw the deceased alive on 2-4-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | | | | | |
| Earl Pass M.D. | | 2-5-68 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | | | |
| EARL PASS, M.D. | | 4001 Welches Ave | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL, (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | |
| Burial | | 2-8-1968 | | Balto. National | | Baltimore | | | | Md. | |
| 24. FUNERAL DIRECTOR | | | | 25a. RECEIVED BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| G. Howard Strong 3207 W. North Ave., | | | | FEB 7 1968 | | | | [Signature] | | | |

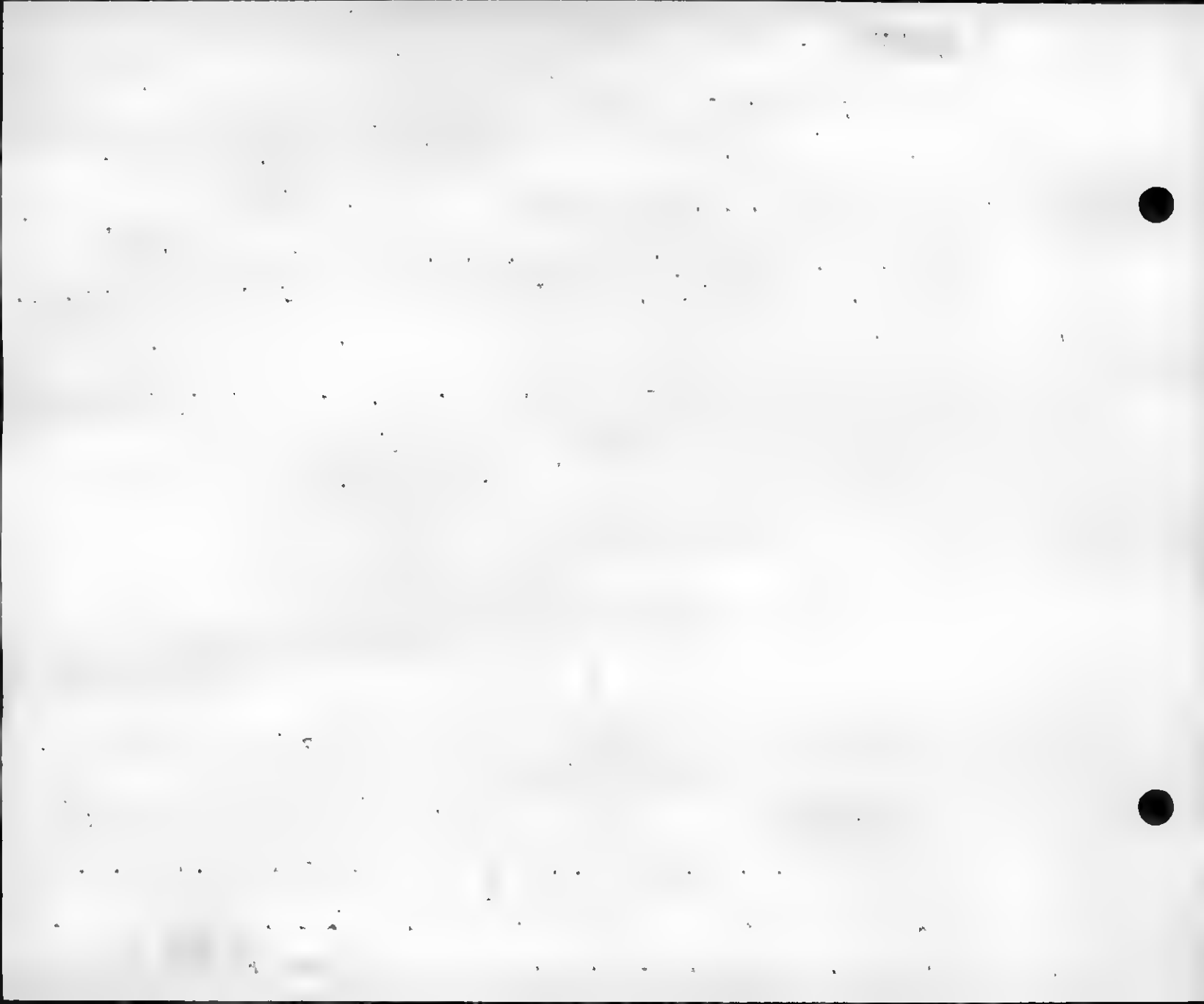


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1-68

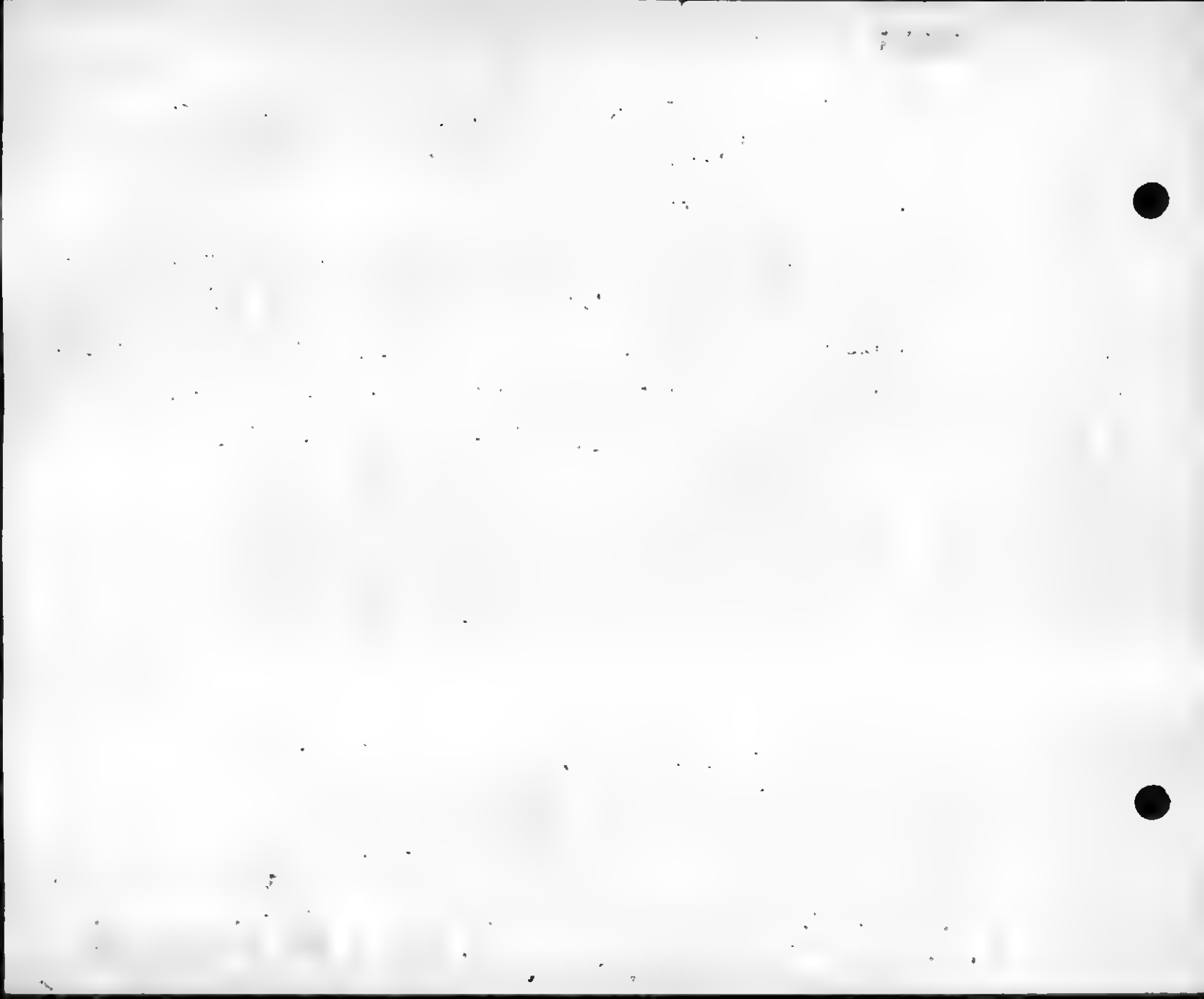
| <div>32327</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>1968</div> | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|
| 1 DECEASED NAME
(Type or print) <i>Sophia Marie</i> <i>Reed</i> | | | | 2a DATE OF DEATH
2 Month 19 Day 68 Year | | | | 2b HOUR
11:30 AM | |
| 3 SEX
F. | | 4 RACE
W. | | 5 DATE OF BIRTH
2/22/1889 | | 6 AGE (In years last birthday)
78 YRS. | | IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH
<i>Baltimore</i> Md. | | | |
| 10 CITY OR TOWN OF DEATH
<i>Parkville</i> | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>3001 1/2 Moreland Ave.</i> | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
<i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institut an- Residence before admission) STATE <i>Md.</i> | | 13b. COUNTY <i>Balto.</i> | | 13c CITY OR TOWN <i>Parkville</i> | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER
<i>3001 1/2 Moreland Ave.</i> | |
| 14. FATHER'S NAME First Middle Last
<i>John</i> <i>Trageser</i> | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
<i>Mary</i> <i>Petri</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, <i>no</i> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
<i>220-12-8914</i> | | 17. INFORMANT Address
<i>Mrs. Margaret Matthaesi same</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>arteriosclerotic heart disease</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>with hypertension</i>
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>1954</i> | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>44</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f LOCATION Street or R.F.D. No City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 26</i> , 19 <i>54</i> , to <i>26-19</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Feb 19</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE
<i>E. J. Alessi</i> | | 22c. PHYSICIAN'S NAME (Type)
<i>E. J. Alessi</i> M.D. | | 22e. ADDRESS
<i>6217 Harford Rd. Balto. Md.</i> | | 22d. DATE SIGNED
<i>2/20/68</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b DATE
<i>2/22/68</i> | | 23c NAME OF CEMETERY OR CREMATORY
<i>Holy Redeemer Cem.</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Balto. Md.</i> | | | |
| 24. FUNERAL DIRECTOR
<i>Leonard J. Ruck Inc. Balto. Md.</i> | | | | 25a. REC'D BY REGISTRAR
DATE <i>5 20 1968</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers—Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

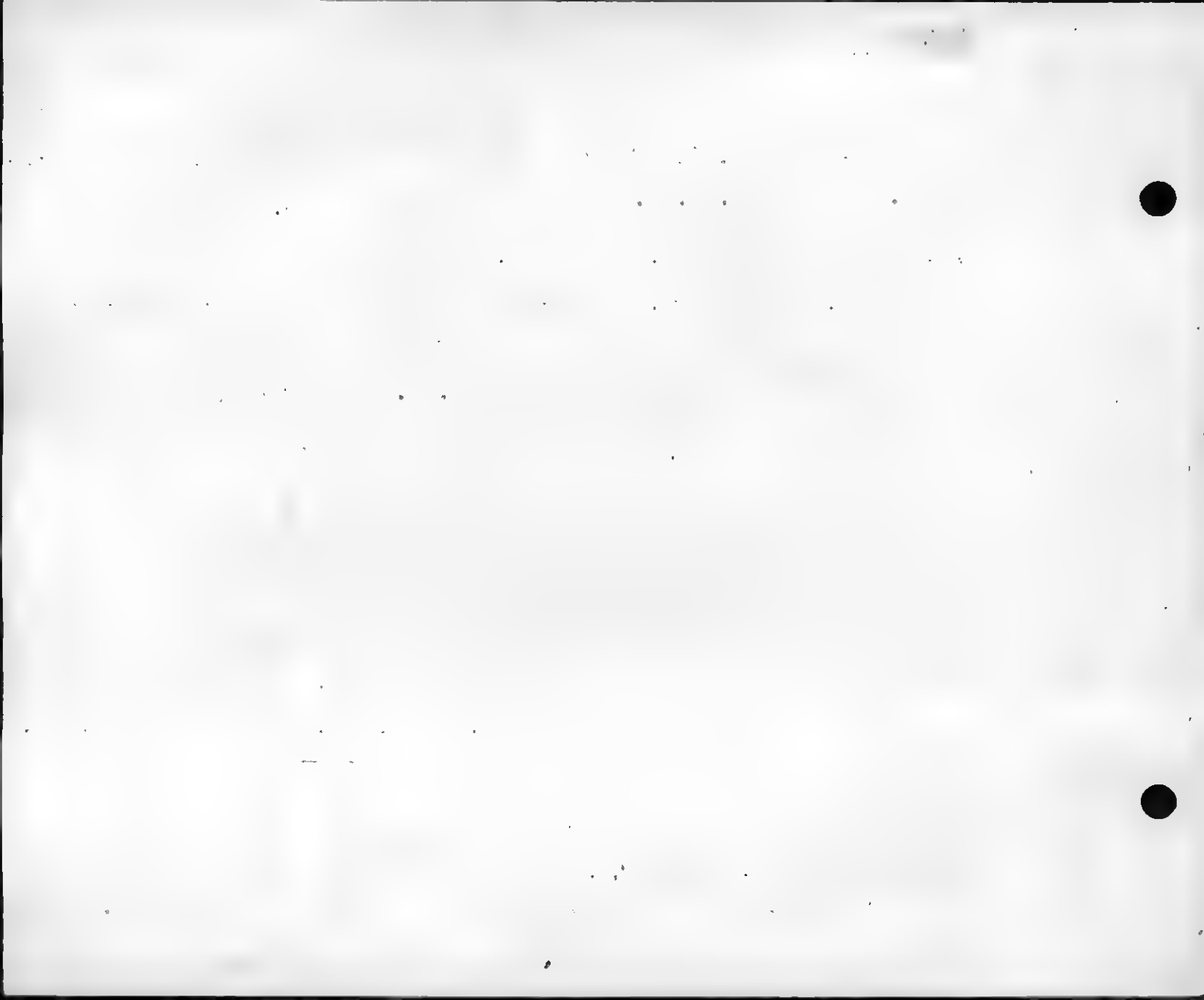
| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|---|---|--|--|--------------------------------|--|-----------------------------------|--|---------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| John Frank Remley | | | | | | Month Day Year | | | 9:45 AM | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | | 6 AGE (In years last birthday) | | IF UNDER YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN |
| Male | | Cauc | | 2/9/1887 | | | 81 YRS | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | | | |
| Md. | | U.S.A. | | | | Balto. Md. | | | | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Balto. 21204 | | | G.B.M.C. | | | Retired CIVIL ENG. | | | P.A.R.R. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Md. | | Balto (12) | | Balto. | | | | 525 Register Ave | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| John Frank Remley | | | Elizabeth Kleiss | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | | |
| No | | 717-07-9527 | | Roberta B Remley | | Above | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | | County State | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2.27, 1968, to 2.28, 1968, that (I) (we) last saw the deceased alive on 2.28, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Robert Bassiri | | | | | | | | DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 2/28/68 | |
| 22d. PHYSICIAN'S NAME (Type) BASSIRI | | | | 22e. ADDRESS GBMC | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | |
| Burial | | 3/1/1968 | | St. James Episcopal | | Bristol, | | | | Pa. | |
| 24. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | | | | 25a. REC'D BY REGISTRAR MAR 1 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | |



FOR STATE
HEALTH DEPT.

1
DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form DM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | |
|---|--|-----------------------------|-------|---|---------|-----------------------------------|------|--|------------------------|-------------------------|---------|--|--|-------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | | | |
| 1 DECEASED NAME
(Type or Print) | | | First | | M. date | | Last | | 2a DATE KNOWN OF DEATH | | 2b HOUR | | | | |
| GEORGE WASHINGTON RICE | | | | | | | | | Month Day Year | | 5:30a | | | | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6 AGE (in years last birthday) | | 7 IF UNDER 1 YEAR | | 8 IF UNDER 24 HRS | | 2c DATE PRONOUNCED DEAD | | | |
| Male | | White | | Oct. 1, 1925 | | 42 YRS | | MONTHS DAYS HOURS MIN. | | Month Day Year | | 2d HOUR | | | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED | | NEVER MARRIED | | 9 COUNTY OF DEATH | | | | | | | |
| Tenn. | | U. S. A. | | WIDOWED | | DIVORCED | | Balto. | | | | Md | | | |
| 10 CITY OR TOWN OF DEATH | | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp to give street address) | | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| Edgemere | | | | 2500 ft. on Morse Rd. | | | | | | | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | 13e STREET AND NUMBER | | | | | |
| Md. | | | | Balto. | | Dundalk | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 7413 St. Patricia Ct. | | | | | |
| 14. FATHER'S NAME | | | | First | | Middle | | Last | | 15 MOTHER'S MAIDEN NAME | | | | First Middle Last | |
| George | | | | | | | | Rice | | Caroline | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16b SOCIAL SECURITY NO | | | | 17. INFORMANT | | | | ADDRESS | | | |
| Yes | | | | 414 20 7338 | | | | U. S. Army Records | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Asphyxia due to Carbon Monoxide Poisoning | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20 AUTOPSY? | | | | | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> | | | | 21b TIME OF INJURY Month, Day, Year | | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| CAUSE OF DEATH | | | | ? P.M. ? 19 | | | | Body found in Chev. truck over steering wheel | | | | | | | |
| 21d INJURY OCCURRED | | | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f LOCATION Street or R.F.D. No City or Town County State | | | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | XXXXX Street (Truck 2500 ft. on Morse Rd. Edgemere Balto. Md. | | | | | | | | | | | |
| 22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | CHIEF MEDICAL EXAMINER | | | | 22b DATE SIGNED | | | | | | | |
| EXAMINER'S NAME (Type) | | | | ASSISTANT MEDICAL EXAMINER | | | | February 7, 1968 | | | | | | | |
| Edward F. Wilson, M.D. | | | | DEPUTY MEDICAL EXAMINER | | | | | | | | | | | |
| ADDRESS (Street, city, town, or county) | | | | | | | | | | | | | | | |
| 23a BURIAL, CREMATION REMOVAL (Specify) | | | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | | | | | | | |
| Burial | | | | Feb. 7, 1968 | | Mt. Vista | | Johnson City, Tenn. | | | | | | | |
| 24 FUNERAL DIRECTOR | | | | 25a REC'D BY REG. STRAR | | | | 25b REG. STRAR'S SIGNATURE | | | | | | | |
| Howard county | | | | Ellicott City Md. | | | | FEB 13 1968 | | | | | | | |
| Funeral Home Harry Witzke | | | | | | | | Judge | | | | | | | |

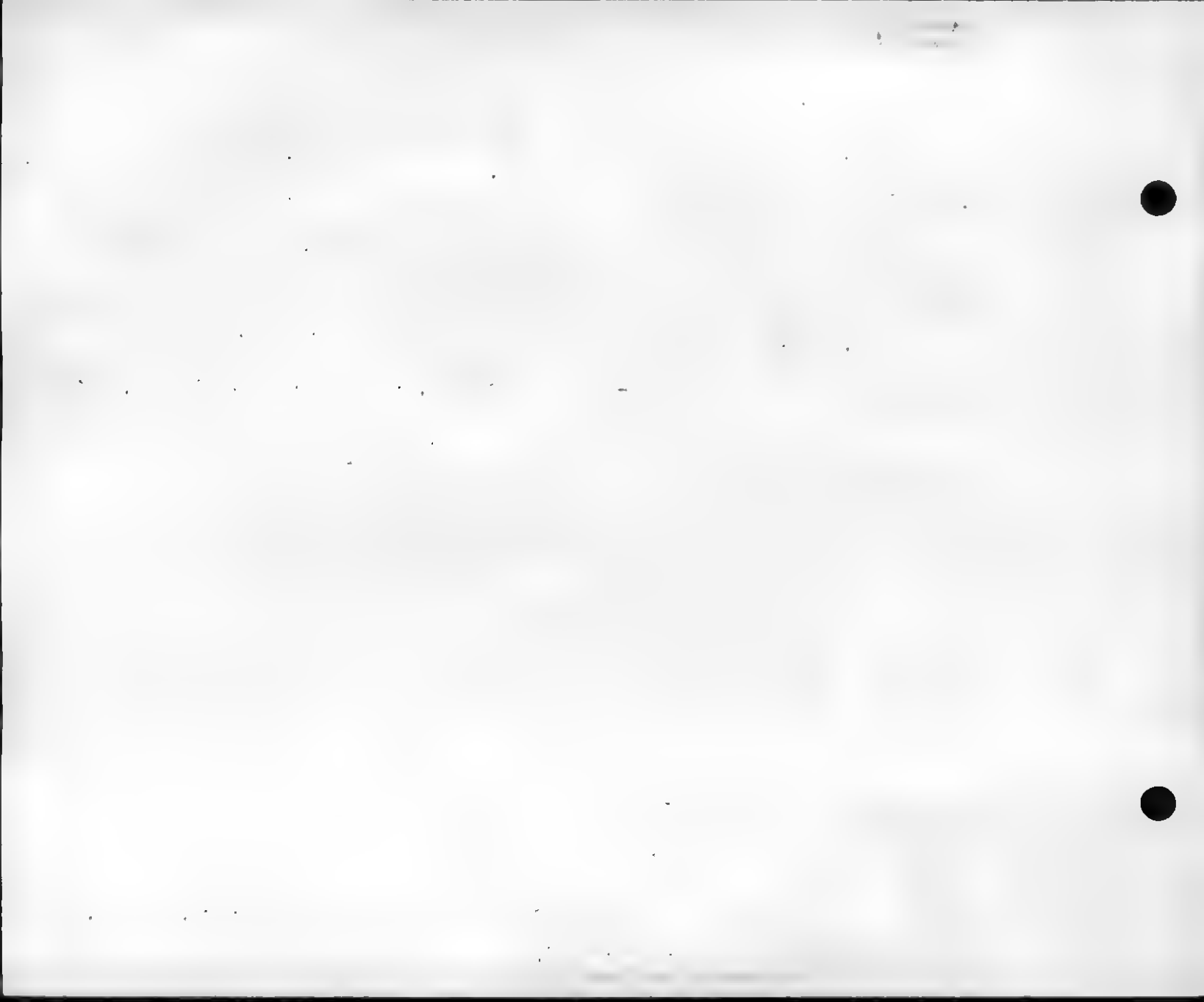


TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--------|---|---|---|------------------------------|---|--|---|---|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1 DECEASED NAME
(Type or Print) | | | First Middle Last | | | 2a DATE KNOWN OF DEATH MATED | | | 2b HOUR | | |
| NANCY | | | MERRITT | | | RIDDLE | | | 2/26 1968 Noon | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (In years last birthday) | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS
HOURS MIN | 2c DATE PRONOUNCED DEAD | | | 2d HOUR | | |
| female | white | 4/7/1920 | 47 YRS | | | February 26, 1968 | | | 4 P.M. | | |
| 7a BIRTHPLACE (State or foreign country) | | | 7b CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 COUNTY OF DEATH | | |
| Maryland | | | USA | | | | | | Baltimore Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| Towson | | | 50 Burkleigh Road | | | homemaker | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if not in hospital give street address) | | | 13b COUNTY | | | 13c CITY OR TOWN | | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| Maryland | | | Baltimore | | | Towson | | | 50 Burkleigh Road | | |
| 14 FATHER'S NAME First Middle Last | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | |
| Dr. Simon W. Merritt | | | | | | Mary Haffelfinger | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b SOCIAL SECURITY NO | | | 17. INFORMANT ADDRESS | | | | | |
| no | | | 213-18-0375 | | | Luther E. Riddle 50 Burkleigh Rd. #21204 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive Subarachnoid Hemorrhage Due To Rupture
Of Aneurysm of Circle of Willis | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | (b) | |
| | | | | | | | | | | (c) | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f LOCATION Street or R.F.D. No | | City or Town | | County | | State | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | Werner U. Spitz, M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b DATE SIGNED | | 2/27/68 | |
| EXAMINER'S NAME (Type) | | | | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | ADDRESS (Street, city, town, or county) | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) | | (County) | | (State) | |
| burial | | 2/29/68 | | Cedar Grove | | Chambersburg, | | | | Pa. | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Mitchell-Wiedefeld Home 6500 York Rd.
Baltimore, Maryland 21212 | | | | | | FEB 29 1968 | | [Signature] | | | |

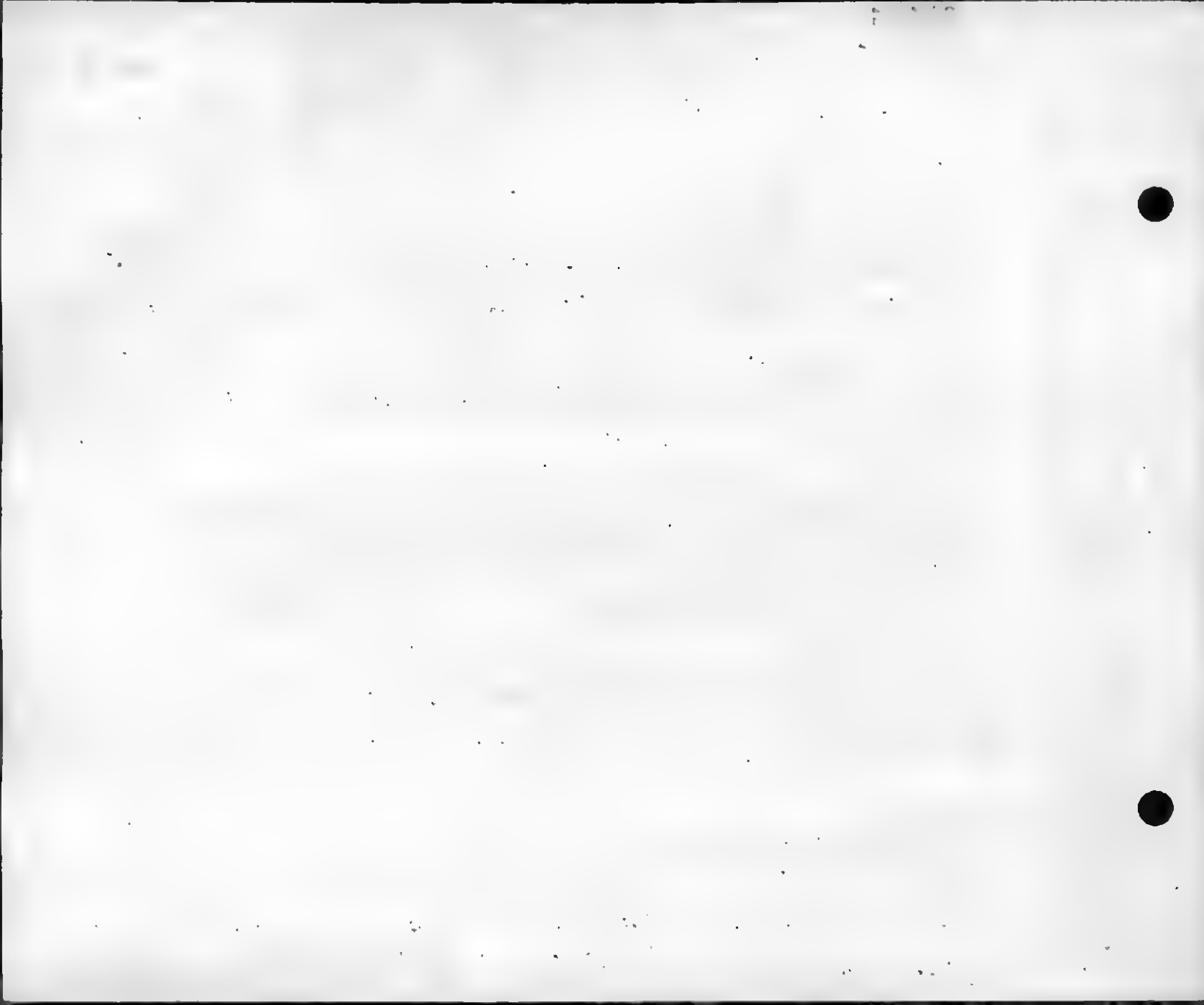


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| 02331 | | | | | | | | | | MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|---|---------------------------------|---|--|--|---|--|---|--|--|---|-----------------------------|--|----------------------------|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | | | |
| Items 2a & 5 Film G398 2/28/68 Kk | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | |
| 1 DECEASED-NAME (Type or print) JAMES F. RIDGELY | | | | | First Middle Last | | | | | 2a. DATE OF DEATH 18 Month 2 Day 16 Year 68 | | | | | 2b. HOUR M | | | | |
| 3 SEX m | | 4 RACE w | | 5. DATE OF BIRTH 3/15/97 | | | | | 6 AGE (In years last birthday) 70 YRS. | | | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | | | |
| 7a. BIRTHPLACE (State or foreign country) MD | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH BALTIMORE Md | | | | | | | | | | | |
| 10 CITY OR TOWN OF DEATH CATONSVILLE | | | 11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 411 INGLETSIDE AVE | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CLERK | | | | | 12b. KIND OF BUSINESS OR INDUSTRY RET. | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD | | | 13b. COUNTY BALTO | | 13c. CITY OR TOWN CATONSVILLE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 410 INGLETSIDE AVE | | | | | | | | | | |
| 14 FATHER'S NAME First Middle Last George W. Ridgely | | | | | 15 MOTHER'S MAIDEN NAME First Middle Last Ella Ebberts | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no or unknown) NO (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO. 215-07-5278 | | | | | 17. INFORMANT MRS. HELEN RIDGELY Address | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY.
4129 IMMEDIATE CAUSE (a) CVA
DUE TO, OR AS A CONSEQUENCE OF A-CVD
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) A-CVD
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 Wks
20 yrs | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from January 1967 , to February 1968 , that (I) (we) last saw the deceased alive on Feb. 18 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. CAF | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE James E. Rowe, M.D. DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED 2/19/68 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) James E. Rowe | | | | | | | | | | 22e. ADDRESS 5550 Baltimore National Pike | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | | | 23b. DATE 2/21/68 | | | | | 23c. NAME OF CEMETERY OR CREMATORY GOOD SHEPHERD | | | | | 23d. LOCATION (City or Town) (County) (State) HOWARD CO. MD. | | | | |
| 24. FUNERAL DIRECTOR E.S. MACNABB | | | | | ADDRESS 301 FREDERICK RD 21228 | | | | | 25a. REC'D BY REGISTRAR DATE FEB 21 1968 | | | | | 25b. REGISTRAR'S SIGNATURE James Judge | | | | |



MD. STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

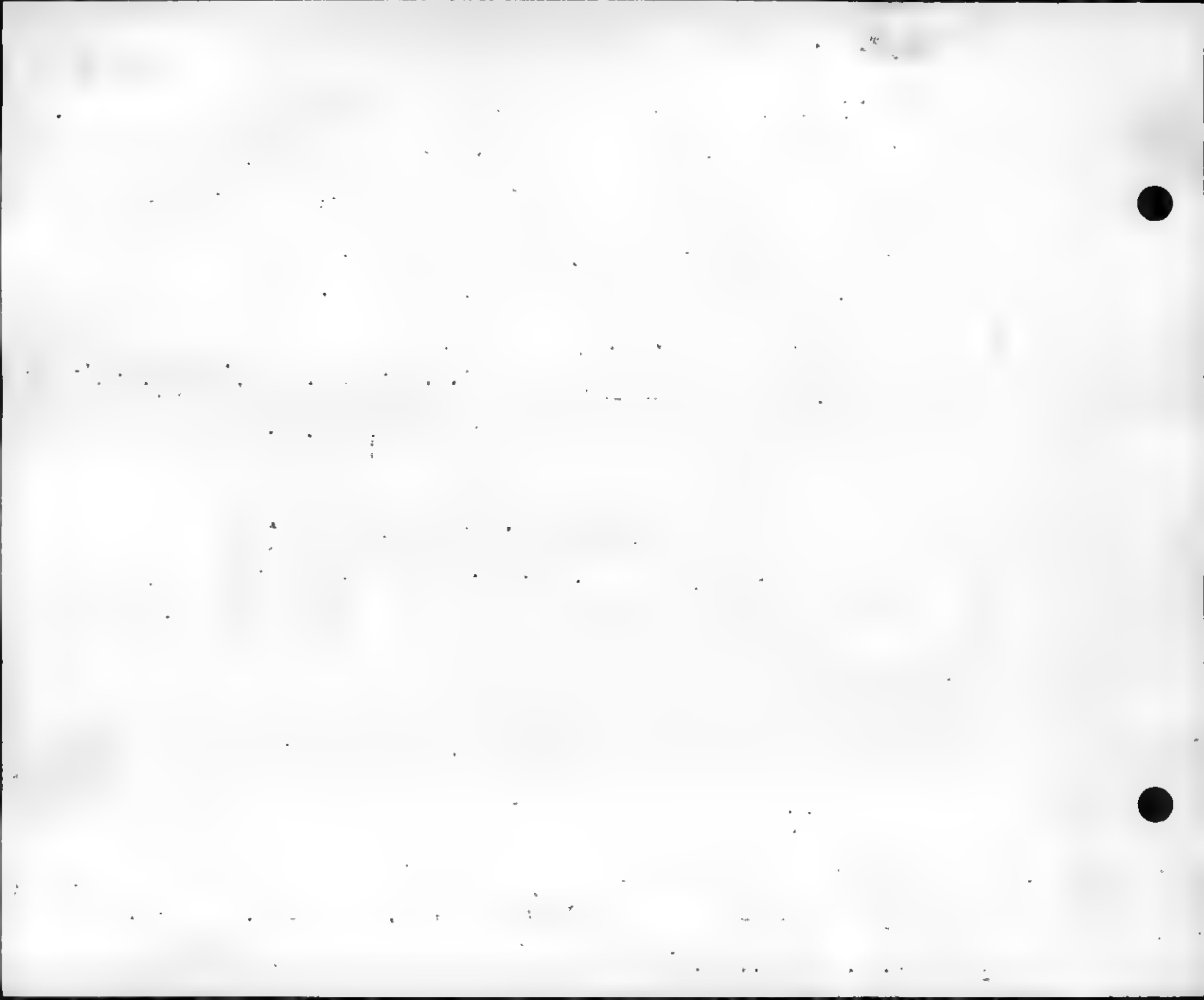
32332

2420

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

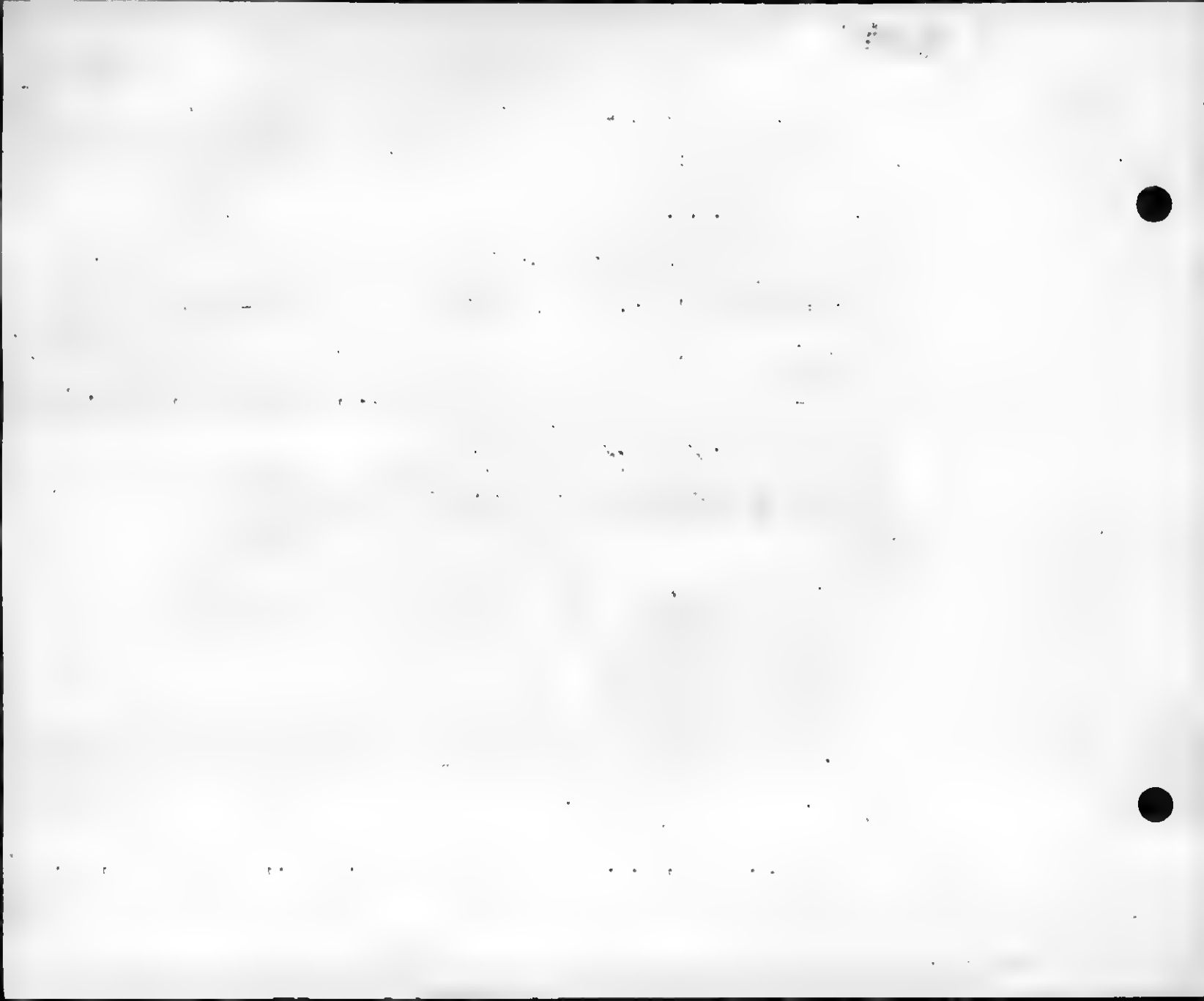
| | | | | | | | | | | |
|--|--|---|--|--|---|--|--|---|---|--|
| 1. DECEASED-NAME
(Type or print) SAMUEL EARL RISTON | | | 2a. DATE OF DEATH
Month February Day 9 Year 1968 | | | 2b. HOUR
2:15 AM | | | | |
| 3 SEX
Male | | 4 RACE
White | | 5. DATE OF BIRTH
2/27/1912 | | 6. AGE (In years last birthday)
55 YRS. | | IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore County, Md. | | | | |
| 10 CITY OR TOWN OF DEATH
Mount Wilson | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Mt. Wilson State Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Laborer | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD. | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
113 S. Calhoun St. | |
| 14. FATHER'S NAME First Samuel Middle Riston Last Riston | | | 15. MOTHER'S MAIDEN NAME First Katherine Middle (?) Last (?) | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes (If yes give war or dates of service) WW 2 | | | | |
| 16b. SOCIAL SECURITY NO.
220-05-7821 | | | 17. INFORMANT Mrs. Samuel E. Riston Balto. Md. 21223 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY EMBOLI
DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROThROMBOSIS LOWER EXTREMITIES
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. 465X (c) FAR-ADVANCED PULMONARY THROMBOSIS | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/24/1968 to 2/9/1968 , that (I) (we) last saw the deceased alive on 2/9/1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
W. Newcomer | | DEGREE MD. | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED | | | | |
| 22d. PHYSICIAN'S NAME (Type)
William Newcomer, M.D. | | 22e. ADDRESS
Mount Wilson, Maryland | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
2-13-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National C. | | 23d. LOCATION (City or Town) (County) (State)
Balto. Md. | | | | |
| 24. FUNERAL DIRECTOR
Witzke F. D., Balto., Md. 21229 | | | | 25a. REC'D BY REGISTRAR
DATE FEB 13 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

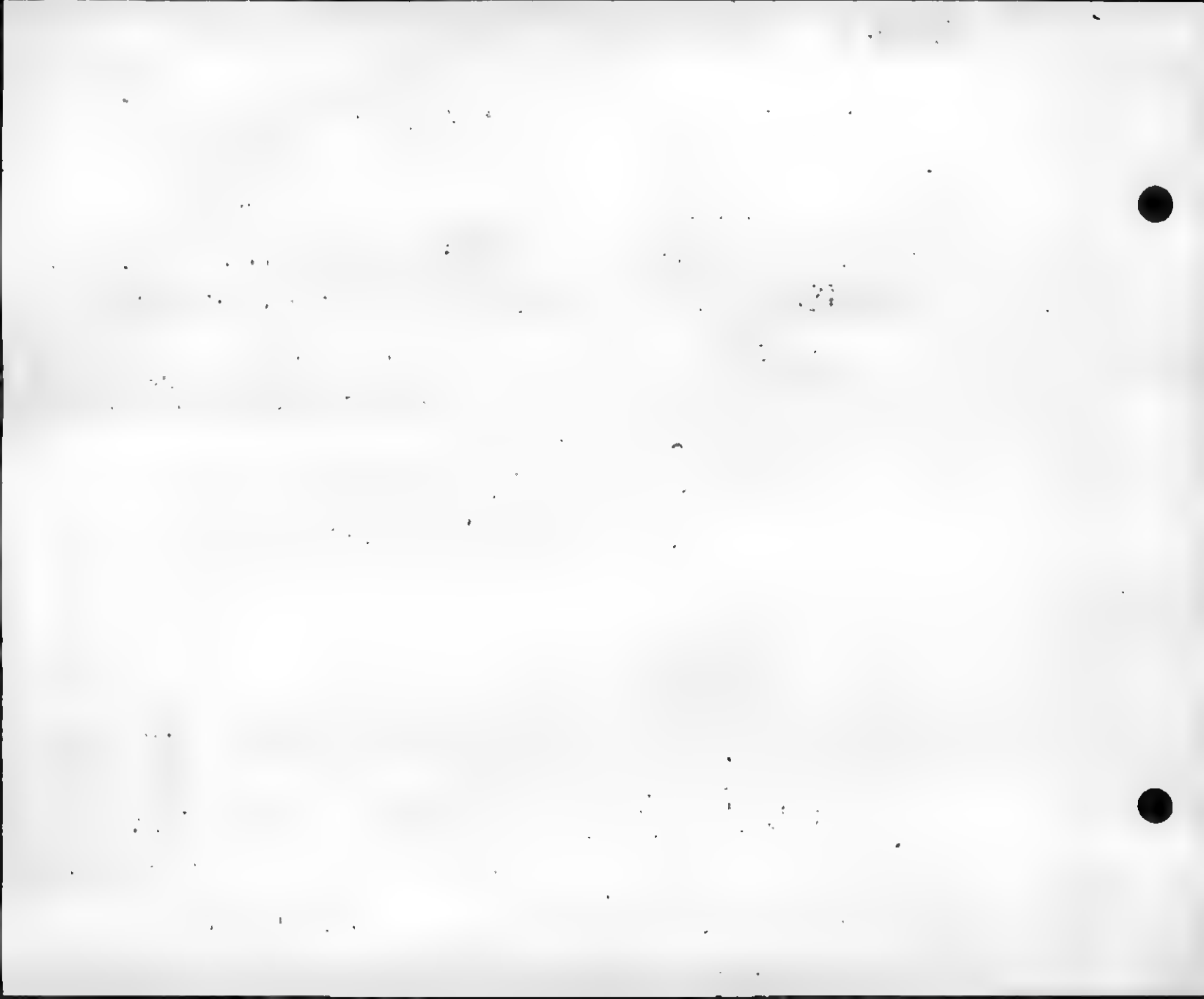
| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|---|---|------------------|---|---|---|------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1 DECEASED-NAME (Type or print) | | | First | | Middle | | Last | | 2a. DATE OF DEATH | | |
| Russell | | | Robert | | ROEHREN | | | | Month 2 Day 27 Year 68 | | |
| 3. SEX | | 4 RACE | | 5 DATE OF BIRTH | | | 6 AGE (In years - last birthday) | | 7b. HOUR a | | |
| Male | | White | | 12/10/63 | | | 4 YRS | | 10:12 | | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 COUNTY OF DEATH | | | | |
| Maryland | | U.S.A. | | | | | Baltimore | | Md | | |
| 10. CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| Owings Mills | | | Rosewood State Hospital | | | Dependent | | none | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE | | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY L.M. 157 | | 13e STREET AND NUMBER | | |
| Maryland | | | St. Mary's Co. | | Patuxent River | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | MOQ 922-C NAS | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | |
| Robert Russell Roehren | | | Lynn Gigi Lawrence | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO | | | 17. INFORMANT | | | Address | | |
| no | | | none | | | Rosewood Records, Owings Mills, Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) External Hydrocephalus | | | | | | | | | | 4 yrs | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Obstruction of Ventricle-Auricular Shunt | | | | | | | | | | 10 days | |
| DUE TO, OR AS A CONSEQUENCE OF (c) 752x | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Subdural hemorrhage at birth with external Hydrocephalus | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | yes | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | |
| 21d INJURY OCCURRED <input type="checkbox"/> White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | | County State | |
| | | | | | | | | | | | |
| 22a. I certify that (a) this hospital attended the deceased from 1/5, 1967, to 2/27, 1968, that (b) (we) last saw the deceased alive on 2/27, 1968, and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above (d) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE | | | | | | DEGREE | | ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c DATE SIGNED | |
| Richard A. Jones | | | | | | | | | | 2/28/68 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | |
| Richard A. Jones, M.D. | | | | | | Rosewood St. Hosp., Owings Mills, Md. | | | | | |
| 23a BURIAL CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) | | (County) | | (State) | |
| Burial | | March 1, 68 | | Arlington National | | Arlington | | Ma. | | | |
| 24 FUNERAL DIRECTOR | | | | | | ADDRESS | | 25a REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | |
| J. F. Eline & Sons | | | | | | Reisterstown, Md. | | MAR 1 1968 | | Charles Jones | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1 DECEASED NAME (Type or print) First Middle Last
Joseph Rosenberg | | | | 2a DATE OF DEATH Month Day Year
FEBRUARY 29 68 | | | | 2b HOUR
6:19 M | | | |
| 3 SEX
MALE | | 4 RACE
WHITE | | 5 DATE OF BIRTH | | | | 6 AGE (In years last birthday)
93 YRS | | 7 UNDER 1 YEAR
MONTHS DAYS HOURS M.N. | |
| 7a BIRTHPLACE (State or foreign country)
POLAND | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE Md | | | | | |
| 10 CITY OR TOWN OF DEATH
PIKESVILLE | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
MILFORD MANOR NURSING HOME | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
TAILOR - RETIRED | | | | 12b. KIND OF BUSINESS OR INDUSTRY
CLOTHING | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND 13b. COUNTY
DANVILLE | | | | 13c. CITY OR TOWN
DANVILLE | | 13d. INSIDE CITY - I.M.T.S? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
312 RANDOLPH AVE. | | | |
| 14. FATHER'S NAME First Middle Last
UNKNOWN | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
UNKNOWN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)
NO | | | | 16b. SOCIAL SECURITY NO.
231-60-4488 | | 17. INFORMANT Address
DR. GERALD WAGGER, 8815 STONEHAVEN RD, RANDALLSTOWN MD 21118 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF (b) Renal failure (insufficiency)
DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| 21d. N.L.R.Y. OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-20-1968 , to 2-29-1968 , that (I) (we) last saw the deceased alive on 2-28-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Gerald Wagger | | | | 22c. DATE SIGNED
2/29/68 | | | | 22d. PHYSICIAN'S NAME (Type)
GERALD WAGGER | | | |
| 22e. ADDRESS
8815 STONEHAVEN RD., RANDALLSTOWN | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| REMOVAL - BURIAL 2-29-68 | | AETZ CHYM | | DANVILLE, VIRGINIA | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS
SOL LEVINSON & BROS., 6010 REISTERSTOWN | | | | 25a. REC'D BY REGISTRAR
MAR 1 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

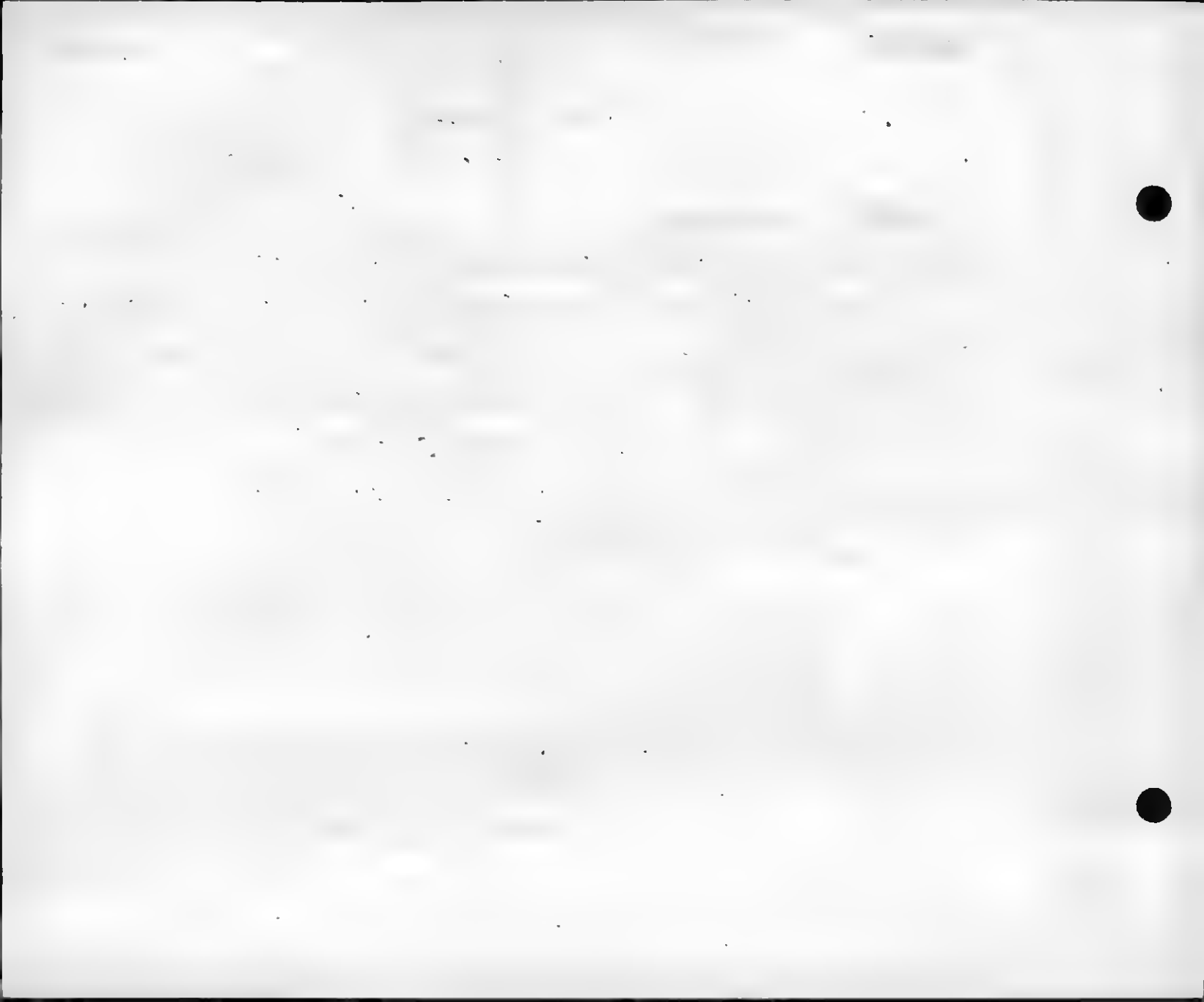


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|-----------------------------|-----------------------------------|-----------------------------|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) KATHERINE D. ROSENTHAL | | | | | | 2a. DATE OF DEATH 2 Month 8 Day 68 Year | | | 2b. HOUR M | | |
| 3. SEX F | | 4. RACE W | | 5. DATE OF BIRTH 2/11/85 | | | 6. AGE (In years last birthday) 82 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH BALTO. | | | | | |
| 10. CITY OR TOWN OF DEATH CATONSVILLE | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 302 RADSTOCK RD. HOUSEWIFE | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Md | | | | 13b. CITY OR TOWN BALTO. CATONSVILLE | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 16 SHADY NOOK AVE. | | | |
| 14. FATHER'S NAME First Middle Last GEORGE DIETRICH | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last KATHERINE EHRMAN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address HERMAN ROSENTHAL JR. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY. | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cardiac arrhythmia | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic myocardial | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Degeneration | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sund , 19 66 , to 8 Feb , 19 68 , that (I) (we) last saw the deceased alive on 8 Feb , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE William J. Bryson | | | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MFD DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED 9 Feb 68 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE 2/10/68 | | 23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK | | 23d. LOCATION (City or Town) BALTO. MD. | | County | | State | |
| 24. FUNERAL DIRECTOR E.S. MACNAB | | | | ADDRESS 301 FREDERICK RD 21228 | | | | 25a. REC'D BY REGISTRAR FEB 13 1968 | | 25b. REGISTRAR'S SIGNATURE | |

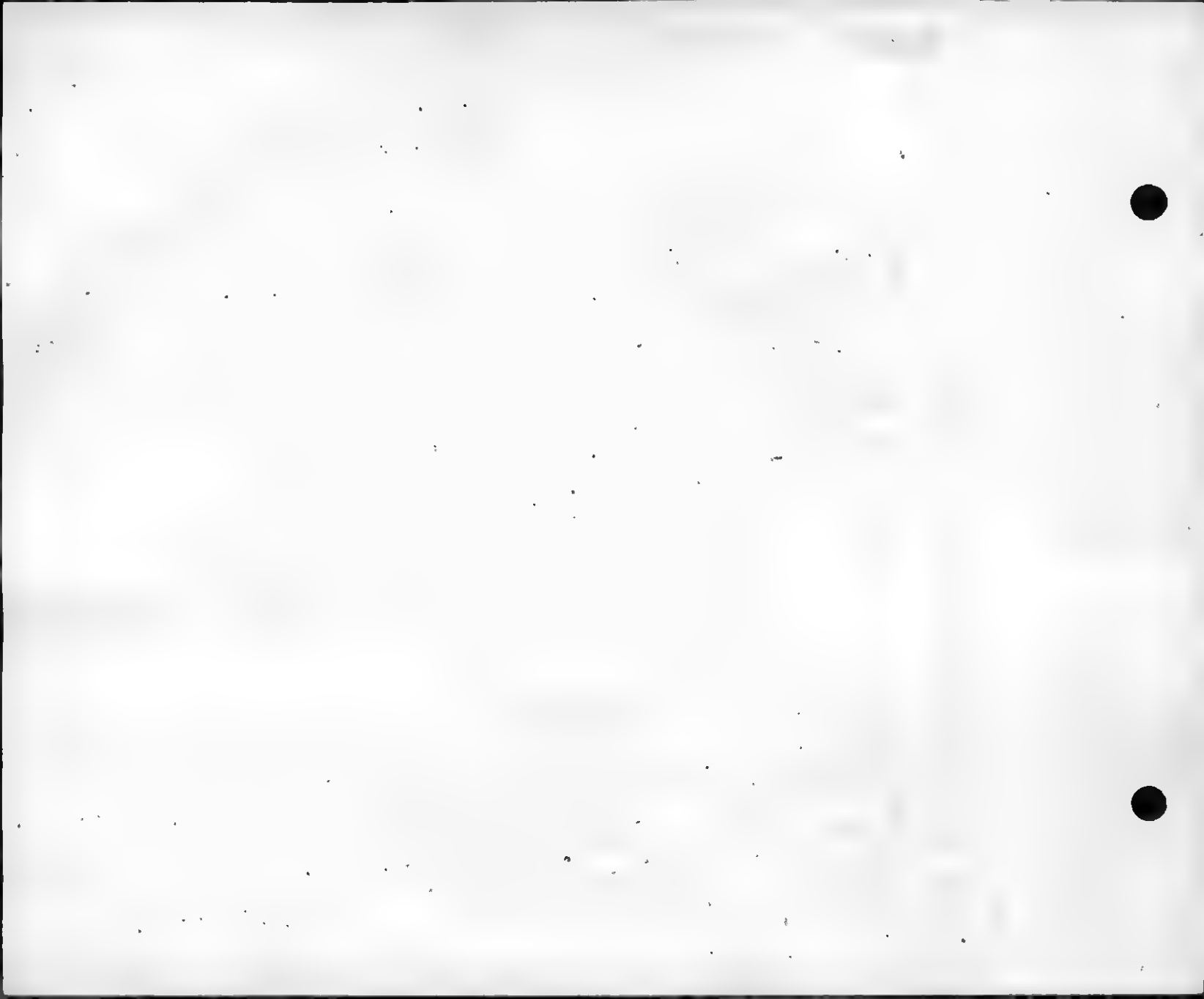


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 CERTIFICATE OF DEATH </div> | | | | | | | | | | | | | |
|--|--|--|--|---|--|---|-----------------------------------|---|--------------------------------------|------------------|---|--|--|
| 1 DECEASED-NAME
(Type or print) | | First | | Middle | | Last | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| INFANT | | MALG | | ROSSELLI | | 2 Month 3 Day 68 year | | | 9:15 PM | | | | |
| 3. SEX | | 4 RACE | | 5. DATE OF BIRTH | | | 6 AGE (In years
lost birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN | | |
| MALE | | WHITE | | 2-3-68 | | | 8 YRS. | | 8 | | 45 | | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | | | | | |
| MARYLAND | | U.S. | | | | | TOWSON | | | Md | | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | |
| BALTIMORE | | | G. B. M. C. | | | NONE | | | NONE | | | | |
| 13a. USUA. RES DENCE (Where deceased lived, if institution: Residence before
admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | | | |
| | | | | | | | | 221E MONUMENT ST. | | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | | | |
| SALVATORE ROSSELLI | | | JOANNA (NMN) SARDISCO | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT | | Address | | | | | | | |
| NO | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory distress syndrome</u>
<u>1111 d</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Premature</u>
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost.
(c) | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | |
| | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY)
OFFICE BUILDING, ETC. | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | | | |
| | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-3-</u> , 19 <u>68</u> , to <u>2-3</u> , 19 <u>68</u> , that (I) (we) last
saw the deceased alive on <u>2-3</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING
PHYS. | | MED.
DIRECTOR | | STAFF
PHYS. | | 22c. DATE SIGNED | | | |
| <u>John C Bolton MD</u> | | | | <input type="checkbox"/> | | <input type="checkbox"/> | | <input checked="" type="checkbox"/> | | <u>2-3-68</u> | | | |
| 22d. PHYSICIAN'S
NAME (Type) | | 22e. ADDRESS | | | | | | | | | | | |
| John C Bolton MD | | Gates Baltimore Medical Center Baltimore Md | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | | | |
| <u>burial</u> | | <u>2/68</u> | | <u>Baltimore National</u> | | <u>Baltimore Md</u> | | | | | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| <u>Philip Henry Am</u> | | <u>2024 Columbia</u> | | <u>FEB 7 1968</u> | | <u>[Signature]</u> | | | | | | | |



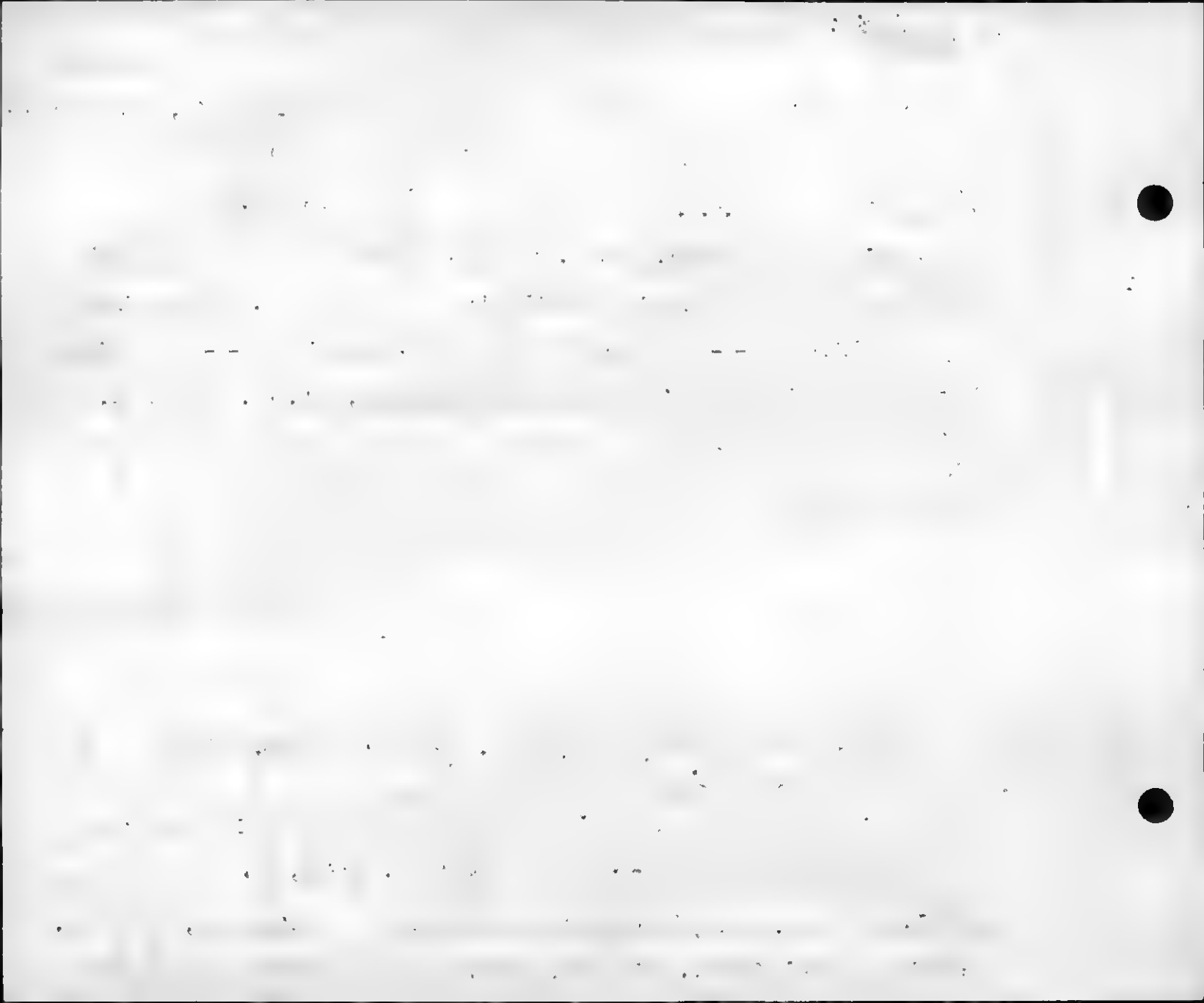
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | |
|--|--|--|--|--|---|--|--|---|--|---|--|--|----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
JOHN | | Middle
ANTHONY | | Last
RUSSO | | 2a. DATE OF DEATH
Month February Day 22 , 19 68 | | 2b. HOUR
12:30AM | | | |
| 3 SEX
MALE | | | 4 RACE
WHITE | | | 5. DATE OF BIRTH
7/28/19 | | | 6 AGE (In years last birthday)
48 YRS. | | IF UNDER 1 YEAR
MONTHS
DAYS | | IF UNDER 24 HRS
HOURS
MIN. | |
| 7a BIRTHPLACE (State or foreign country)
MARYLAND | | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 COUNTY OF DEATH
BALTIMORE Md | | | | | |
| 10 CITY OR TOWN OF DEATH
FORT HOWARD | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
VETERANS ADMIN. HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
MECHANIC | | | 12b. KIND OF BUSINESS OR INDUSTRY
MARINE | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE
MARYLAND | | | 13b COUNTY
BALTIMORE | | | 13c CITY OR TOWN
BALTIMORE | | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER
2319 E. FAYETTE STREET | | | |
| 14 FATHER'S NAME
First JOSEPH Middle - Last RUSSO | | | 15 MOTHER'S MAIDEN NAME
First JOSEPHINE Middle - Last GLORSIO | | | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) YES (If yes give war or dates of service) WWII | | | 16b SOCIAL SECURITY NO
217 07 54 26 | | | 17 INFORMANT
Address CLINICAL RECORDS, VAH, FT. HOWARD, MD. | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
162.1 IMMEDIATE CAUSE (a) CANCER OF THE LUNG
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Months | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
1. | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) | | | | | | | | |
| 21d INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f LOCATION Street or R.F.D. No City or Town County State | | | | | | | | |
| 22a. I certify that he (this hospital) attended the deceased from Feb. 12 , 19 68 , to Feb. 22 , 19 68 , that he (we) last saw the deceased alive on Feb. 22 , 19 68 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. He (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Chong Choon Han | | | DEGREE | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
2/22/68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
CHONG CHOON HAN, M.D. | | | 22e. ADDRESS
VAH, FT. HOWARD, MD. | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | 23b DATE
Feb. 24, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
HOLY REDEEMER CEMETERY | | | 23d LOCATION (City or Town) (County) (State)
BALTIMORE, MD. | | | | | | |
| 24 FUNERAL DIRECTOR
BERNARD DAHEROWSKI, 2818 E. BALTIMORE, BALTO. MD. | | | ADDRESS | | | 25a. REC'D BY REGISTRAR
29 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | |

MEDICAL CERTIFICATION ON



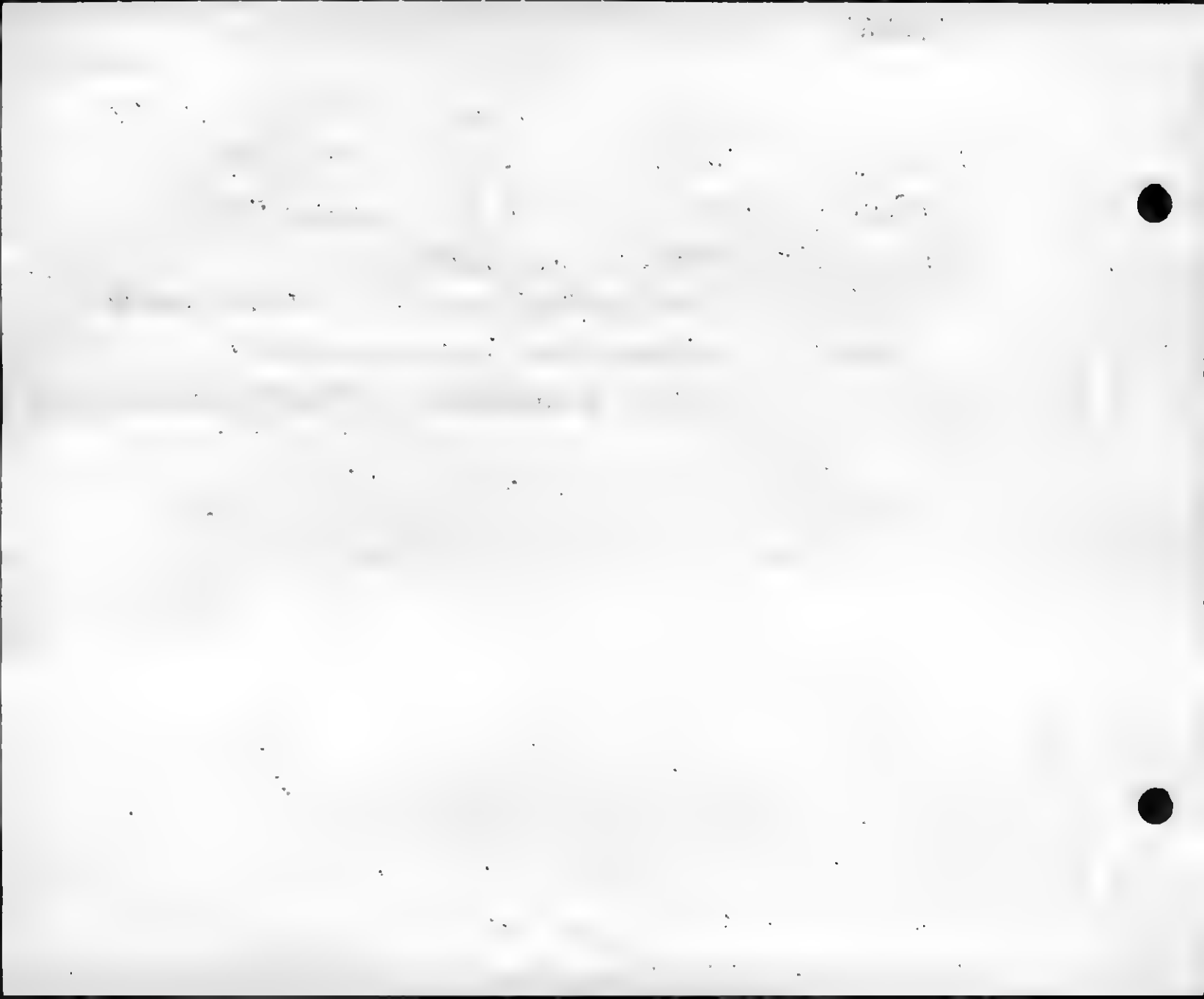
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|--|--|--|--|-----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| ANNA | | | E RYDER | | | FEB. 16. 68. | | M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | |
| FEMALE. | | WHITE | | JULY 2-1890. | | 77 YRS. | | MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| VIRGINIA | | U.S.A. | | | | BALTIMORE | | Md | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| COCKEYSVILLE | | | MARYLAND MASONIC HOMES | | | HOUSEWIFE | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. NSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 3e. STREET AND NUMBER | |
| MD. | | BALTOCOUNTY | | BALTIMORE | | YES | | 5 BRIARWOOD RD. | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| HENRY | | | HARRINGTON | | | FLORENCE LOWERY. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | |
| No | | | 215-05-9263 | | Sprellings Rn. Maryland Masonic Homes. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | | | | | | | | |
| 4. DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| arteriosclerotic heart disease | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| 3. atrial fibrillation | | | | | | | | | |
| (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| 1. Pulmonary embolism | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | City or Town | | County State | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | Street or RFD No | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from August 1965, to Feb 16, 1968, that (I) (we) lost saw the deceased alive on Feb 16, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. 4:55 PM. 2/16/68 | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED | |
| JAMES HED HAMED MD | | | | | | | | 2/16/68 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | | |
| JAMES HED HAMED MD | | | | MASONIC HOME | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| BURIAL | | 2/19/68 | | LORRAINE PARK CEMETERY | | WOODLAWN, MD. | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REG. STRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Wm. COOK-BROOKS TOLSON, 1050 YORK RD 21204 | | | | DATE | | FEB 21 1968 | | Charles J. [Signature] | |

MEDICAL CERTIFICATION



FOR STATE
HEALTH DEPT.

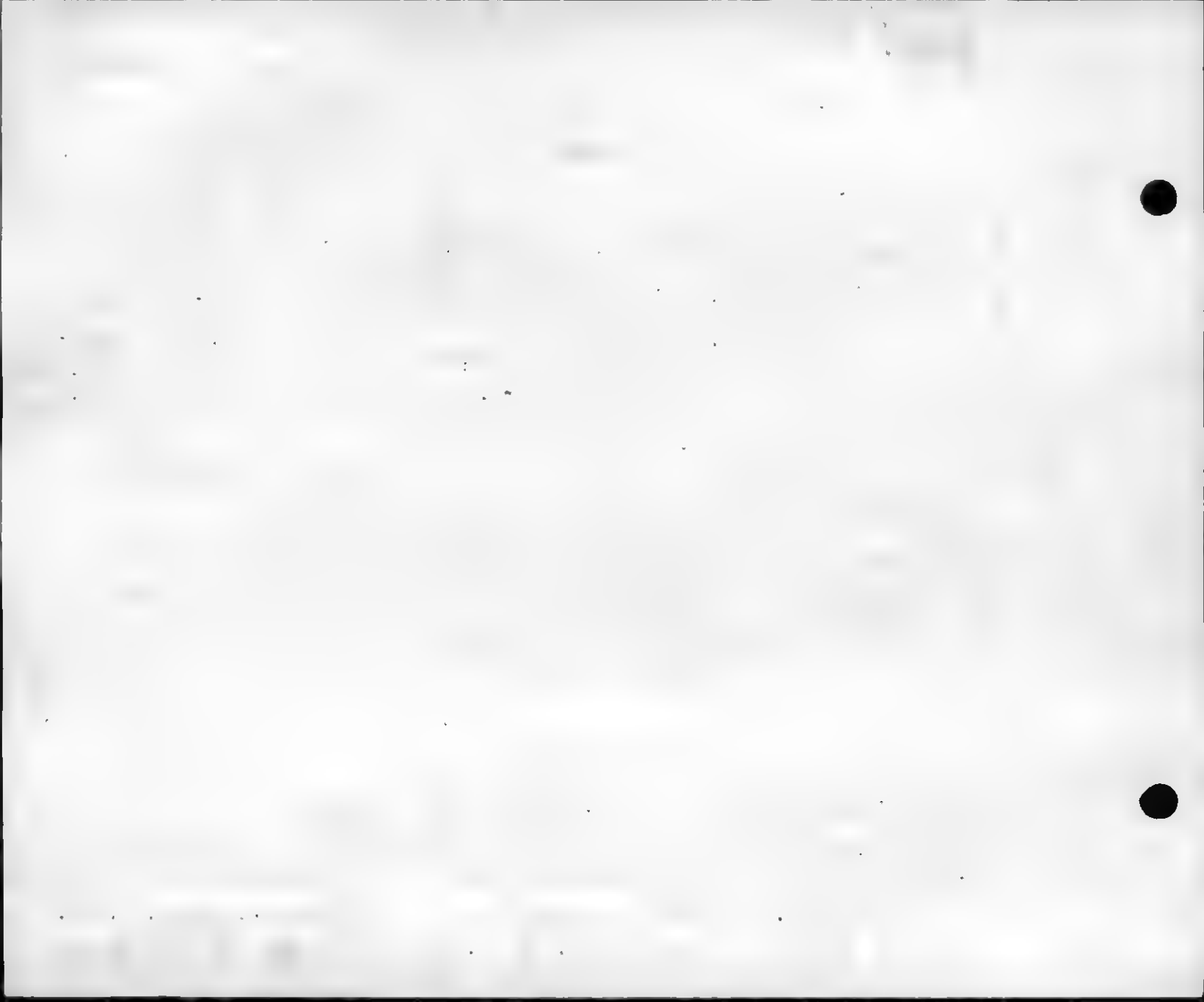
TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Page 1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

32339

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

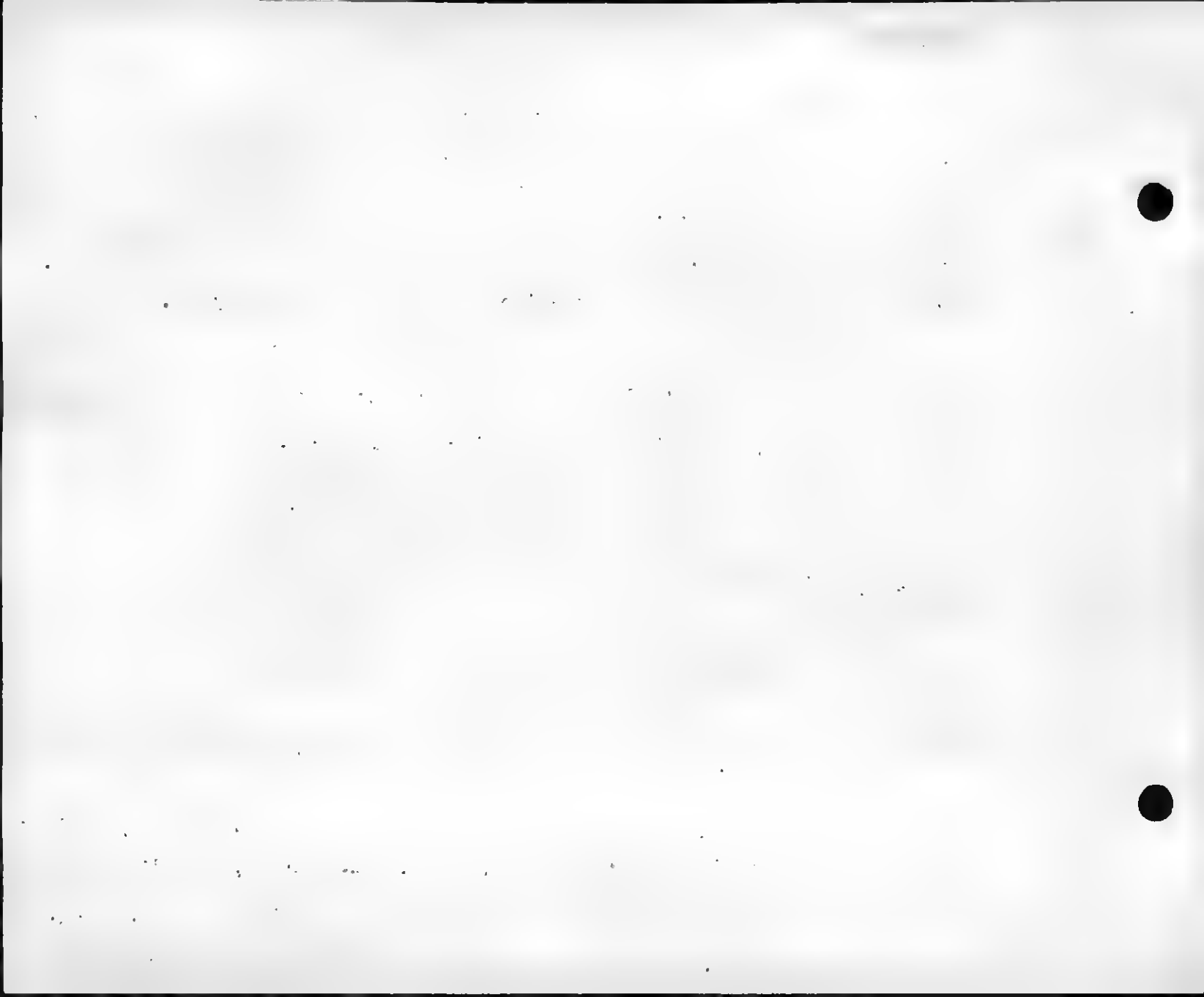
| | | | | | | | |
|--|-----------------|--|---|---|--|---|--|
| 1. DECEASED NAME
(Type or Print) MARGARET | | First Middle Last SANDEBECK SANDEBECK | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year Feb 19 1968 | | 2b. HOUR 10:55 PM | |
| 3 SEX F | 4 RACE W | 5 DATE OF BIRTH 2-10-93 | 6 AGE (In years and birthday) 75 VRS | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | | IF UNDER 24 HRS HOURS MIN | |
| 7a BIRTHPLACE (State or foreign country) Maryland | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH BALTIMORE Md. | |
| 1d CITY OR TOWN OF DEATH Towson | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's Hosp | | 12a. USLA OCCUPATION (Kind of work done during most of working life, even if retired) NONE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a USLA RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD | | 13b COUNTY BALTO. | | 13c CITY OR TOWN Towson | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e STREET AND NUMBER 313 GARDEN RD. | | 14 FATHER'S NAME First Middle Last Milton H. Crandall | | 15 MOTHER'S MAIDEN NAME First Middle Last Mary J. Carter | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | |
| 16b. SOC. SEC. SECURITY NO. 215-09-0967D | | 17 INFORMANT: Dghtr-in-law | | ADDRESS Towson, Md. 21204 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SUBDURAL HEMATOMA
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 2d. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day Year 2/18/68 HOUR A.M. PM | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) FELL DOWN STEPS | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home | | 21f. LOCATION Street or R.F.D. No 313 GARDEN RD City or Town Towson County BALTO State MD | | 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | |
| ACTUAL SIGNATURE William A. Pillsbury | | EXAMINER'S NAME (Type) William A. Pillsbury | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 2/20/68 | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE Feb. 23, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial | | 23d. LOCATION (City or Town) (County) (State) Parkville, Balto. Co., Md. | |
| 24. FUNERAL DIRECTOR STEWART & MOWEN CO. 108 W. North Av., Balto. 1 | | 25a. REC'D BY REGISTRAR FEB 21 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the other papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>32340</div> <div> <div>3</div> <div>1</div> </div> <div> <div>2</div> <div>3</div> </div> <div> <div>4</div> <div>5</div> </div> <div> <div>6</div> <div>7</div> </div> <div> <div>8</div> <div>9</div> </div> <div> <div>10</div> <div>11</div> </div> <div> <div>12</div> <div>13</div> </div> <div> <div>14</div> <div>15</div> </div> <div> <div>16</div> <div>17</div> </div> <div> <div>18</div> <div>19</div> </div> <div> <div>20</div> <div>21</div> </div> <div> <div>22</div> <div>23</div> </div> <div> <div>24</div> <div>25</div> </div> <div> <div>26</div> <div>27</div> </div> <div> <div>28</div> <div>29</div> </div> <div> <div>30</div> <div>31</div> </div> <div> <div>32</div> <div>33</div> </div> <div> <div>34</div> <div>35</div> </div> <div> <div>36</div> <div>37</div> </div> <div> <div>38</div> <div>39</div> </div> <div> <div>40</div> <div>41</div> </div> <div> <div>42</div> <div>43</div> </div> <div> <div>44</div> <div>45</div> </div> <div> <div>46</div> <div>47</div> </div> <div> 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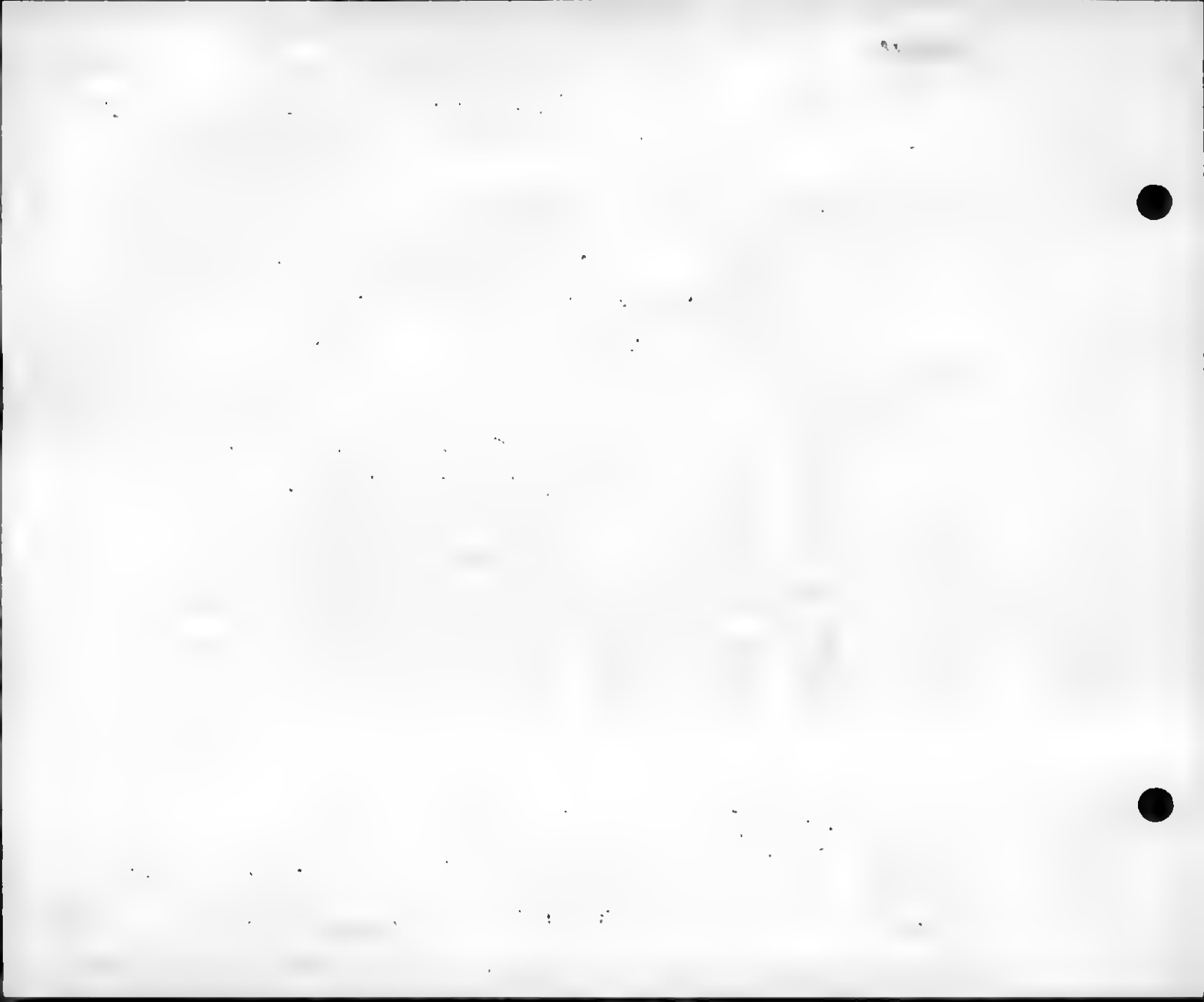


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | First
<i>Caroline</i> | | Middle
<i>L</i> | | Last
<i>Saunders</i> | | 2a. DATE OF DEATH
Month <i>Feb</i> Day <i>4</i> Year <i>69</i> | | 2b. HOUR
M | |
| 3 SEX
<i>Female</i> | | 4 RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>8-1-1877</i> | | 6. AGE (In years last birthday)
<i>90</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | IF UNDER 24 HRS.
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Balto. Co. - Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Baltimore</i> Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Catonsville</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Summit Nurs. Hme</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
<i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE
<i>Md.</i> | | 13b. COUNTY
<i>Howard</i> | | 13c. CITY OR TOWN
<i>RFD. 2 - E.C.</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| 14. FATHER'S NAME First
<i>George</i> | | Middle
<i>Wolfe</i> | | Last
<i>Wolfe</i> | | 15. MOTHER'S MAIDEN NAME First
<i>Mary</i> | | Middle
<i>Hoffman</i> | | Last
<i>Hoffman</i> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) <i>no</i> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
<i>G. Nobel Saunders</i> | | Address
<i>RFD 2 Ellicott City, Md.</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
<i>4274</i> IMMEDIATE CAUSE (a) <i>Chronic Congestive Heart Failure</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arrtrial Fibrillation</i>
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Emil J. Slack</i> | | DEGREE | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>Emil J. Slack</i> | | 22e. ADDRESS
<i>3350 Wilkins Ave BALTO.</i> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>Feb. 7, 1968</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>National Cemetery - Balto.</i> | | 23d. LOCATION (City or Town)
<i>Baltimore</i> | | (County)
<i>Md.</i> | | (State) | |
| 24. FUNERAL DIRECTOR
<i>Higinbotham-Slack</i> | | ADDRESS
<i>106 Columbia Rd. Ellicott City, Md.</i> | | 25a. REC'D BY REGISTRAR
DATE <i>FEB 8 1968</i> | | 25b. REGISTRAR'S SIGNATURE
<i>James J. Jones</i> | | | | | |

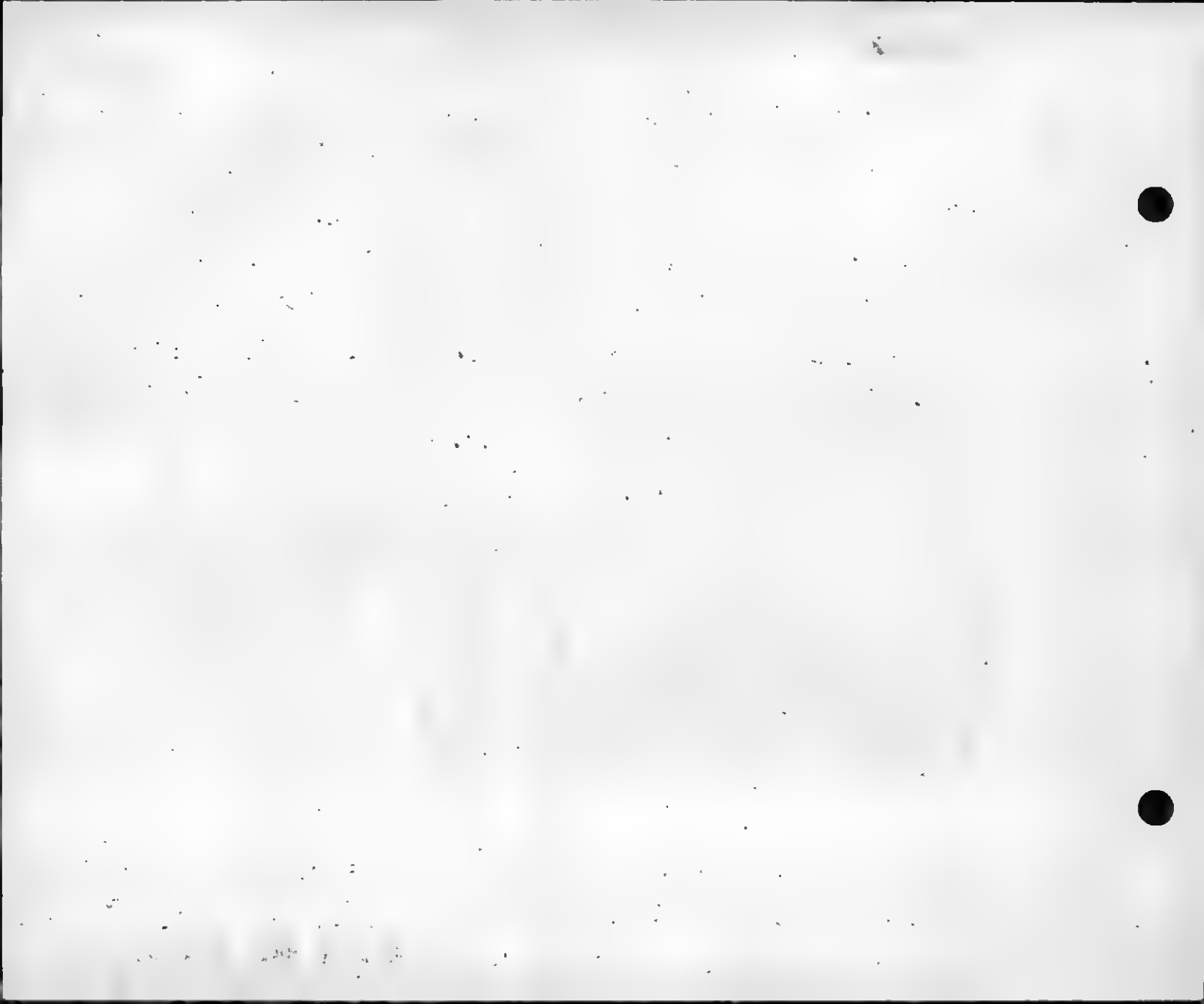


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Items 21&22a Film 398
3-11-68
22312
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|---|---|---|--|---|--|
| 1 DECEASED NAME (Type or print) First Middle Last
<i>St. M. Pamphalia Schmitt</i> | | | 2a DATE OF DEATH Month Day Year
<i>2 8 1968</i> | | | 2b. HOUR
<i>10 P M</i> | |
| 3 SEX
<i>Female</i> | | 4 RACE
<i>White</i> | | 5 DATE OF BIRTH
<i>9-18-1873</i> | | 6 AGE (In years last birthday) <i>94</i> YRS. | |
| 7a BIRTHPLACE (State or foreign country)
<i>Penn.</i> | | 7b CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Baltimore</i> Md. | |
| 10 CITY OR TOWN OF DEATH
<i>Glen Arm</i> | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Glen Arm, Road</i> | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
<i>Teacher</i> | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE
<i>Md.</i> | | 13b. COUNTY
<i>Baltimore</i> | | 13c CITY OR TOWN
<i>Glen Arm, Rd.</i> | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME First Middle Last
<i>Philip Schmitt</i> | | | 15. MOTHER'S MAIDEN NAME First Middle Last
<i>Catherine Tittelbach</i> | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
<i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>218-54-0865</i> | | 17. INFORMANT
<i>St. M. Kathleen</i> | | Address
<i>same</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Coronary Heart Failure</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Fracture Left Hip</i>
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>+</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY
HOUR A.M. Month Day Year
<i>6 P.M. Nov 19 1968</i> | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
<i>Slipped on floor</i> | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.
<i>Villa Maria Rest Home</i> | | 21f LOCATION Street or R.F.D. No City or Town County State
<i>Glen Arm Balto. Md.</i> | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <i>11-3-</i> , 19 <i>66</i> , to <i>2-8</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>2-8 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death <i>Natural causes</i> | | | | | | | |
| 22b. SIGNATURE
<i>Henry L. McCorkle</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>HENRY L. MCCORKLE</i> | | | | 22e. ADDRESS
<i>Phoenix Maryland 21431</i> | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE
<i>2-12-68</i> | | 23c NAME OF CEMETERY OR CREMATORY
<i>SISTERS CEMETERY</i> | | 23d LOCATION (City or town) (County) (State)
<i>Glen Arm Balt. Maryland</i> | |
| 24 FUNERAL DIRECTOR
<i>RAYMOND J. CURRAN</i> | | | | 25a. REC'D BY REGISTRAR
DATE <i>FEB 19 1968</i> | | 25b REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

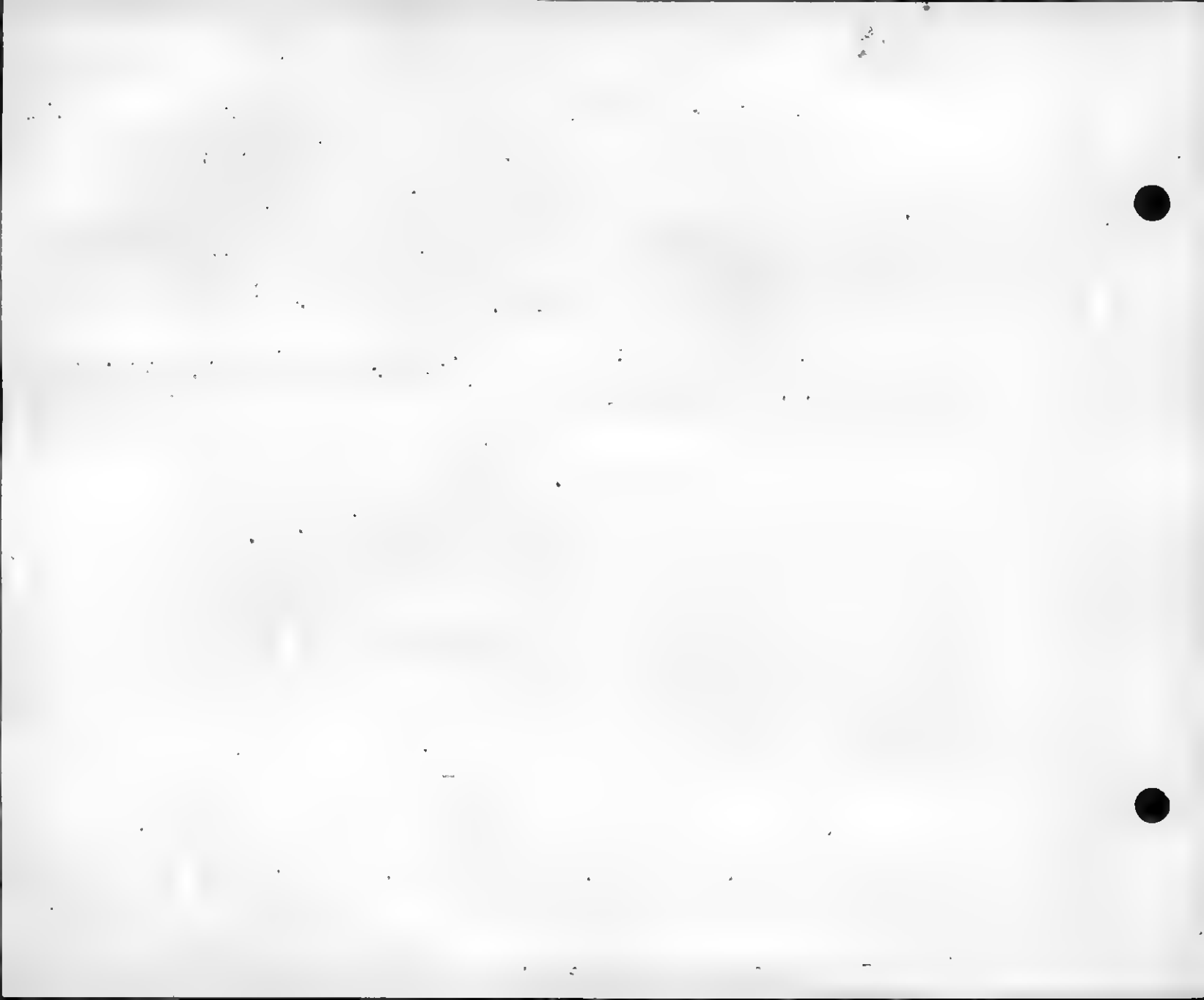


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

177

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED-NAME (Type or print)
First Middle Last
Edmund Carroll Schofield | | | | | 2a. DATE OF DEATH
Month Day Year
2 24 68 | | | 2b. HOUR
7:50 AM | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH
2/2/1938 | | 6. AGE (In years last birthday)
30 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Stella Maris Hospice | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
General Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY
Ball Park | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE
Md. | | 13b. COUNTY
- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY (Y/N) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
2900 Greenmount Ave | |
| 14. FATHER'S NAME First Middle Last
Henry Carroll Schofield | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Rebecca Jane Evans | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
yes | | 16b. SOCIAL SECURITY NO
215 00 0397 | | 17. INFORMANT Miss Mary Shehan 100 W. Cold Spring Lane
Hospice records | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia
4129 DUE TO, OR AS A CONSEQUENCE OF ASCVD
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Best Chronic Hypertension
(b) _____
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/11/67 , 19____, to 2/24/68 , 19____, that (I) (we) last saw the deceased alive on 2/23/68 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Robert J. Mahon | | | | DEGREE
M.D. | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
2/24/68 | |
| 22d. PHYSICIAN'S NAME (Type)
Robert J. Mahon, M.D. | | | | 22e. ADDRESS
204 E. Joppa Rd | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL, (Specify)
Burial | | 23b. DATE
2/27/68 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR
Mitchell-Wiedefeld Home | | | | ADDRESS
6500 York Rd. Baltimore, Maryland 21212 | | 25a. REC'D BY REGISTRAR
FEB 29 1968 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

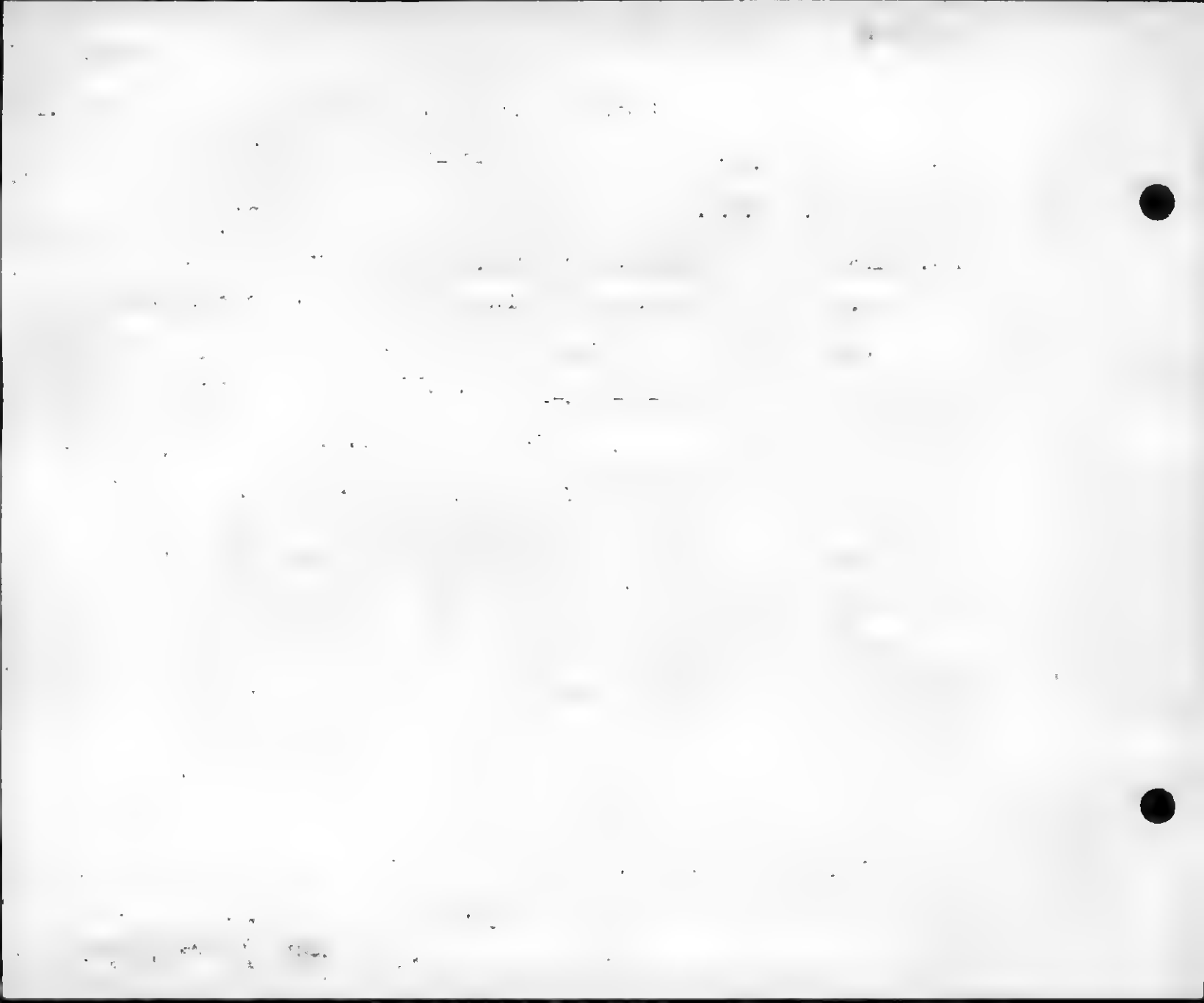


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|--------------|-----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | | | |
| Mary Anne Elizabeth Schwartz | | | | | | 2 Month 18 Day 1968 | | 1.15A | | | |
| 3 SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | |
| Female | | White | | 6-16-1880 | | | 87 YRS. | | IF UNDER 24 HRS HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Baltimore MD. | | U.S.A. | | | | Baltimore Md | | | | | |
| 10 CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Lutherville | | | College Manor Nursing Home | | | House Wife | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Md. | | | Baltimore | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 212 Rodgers Forge | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S M A DEN NAME | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | |
| John White | | | Jennie McGibbon | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | |
| No | | | 216-05-9509-D | | Mrs. Elizabeth S. Totman | | 15 Meadow Rd. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Myocardial infarction | | | | | | | | | | 10 min | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease | | | | | | | | | | 11+ yrs | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 4201 Diabetes mellitus | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED <input type="checkbox"/> White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No | | City or Town | | County State | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July, 1966, to Feb 16, 1968, that (I) (we) last saw the deceased alive on Jan 9, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | 22c. DATE SIGNED | | | | | | |
| Dr. Frederick J. Vollmer MD | | | | | Feb 16, 1968 | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | 22e. ADDRESS | | | | | | |
| Dr. Frederick J. Vollmer | | | | | 6100 York Road, Balto, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | |
| Burial | | 2/19/68 | | Parkwood Cemetery | | Baltimore Co., Md. | | | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Leonard J. Ruck, Inc.-Balto, Md.-14 | | | | | FEB 16 1968 | | Charles Judge | | | | |



FOR STATE
HEALTH DEPT.

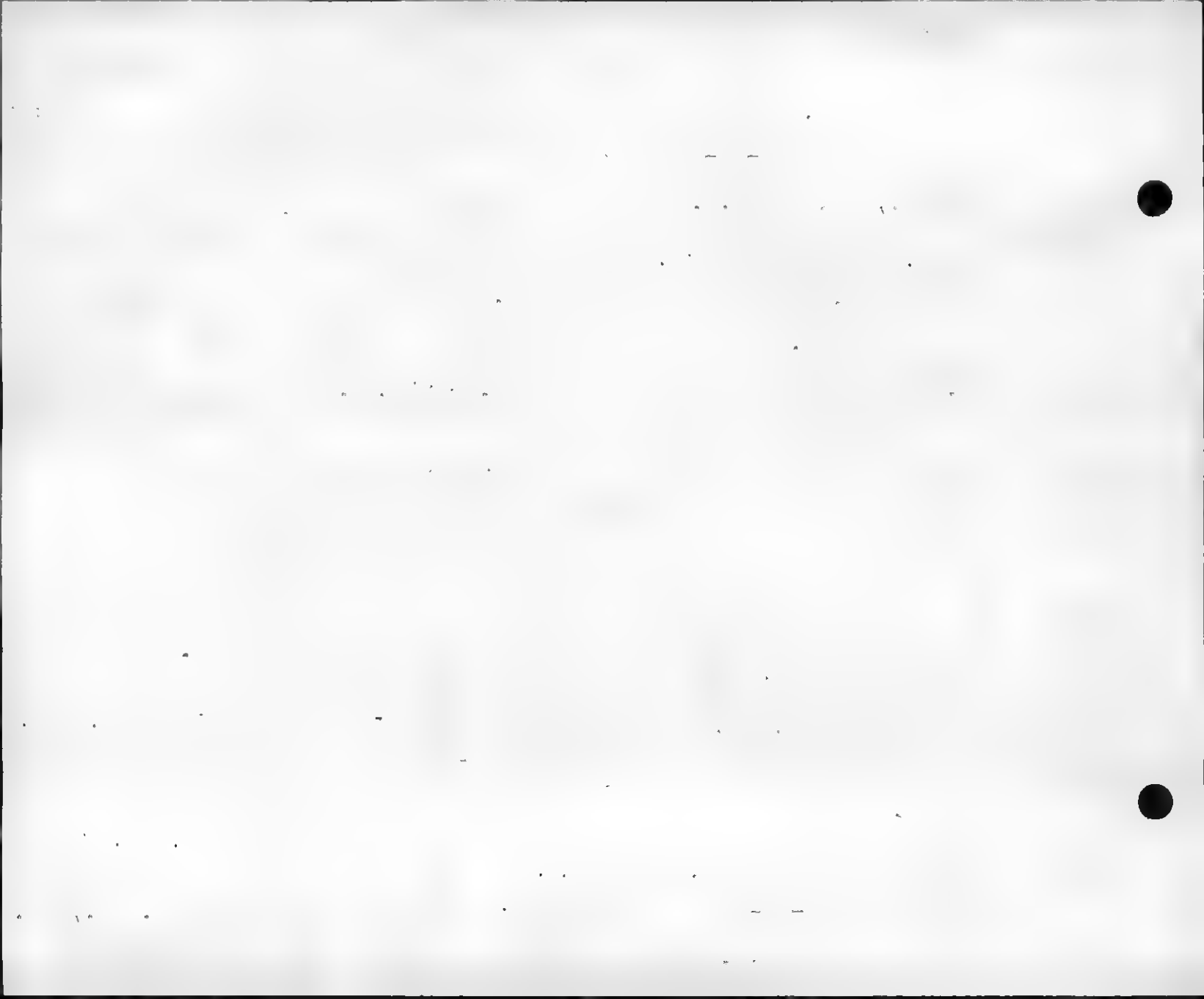
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02345

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

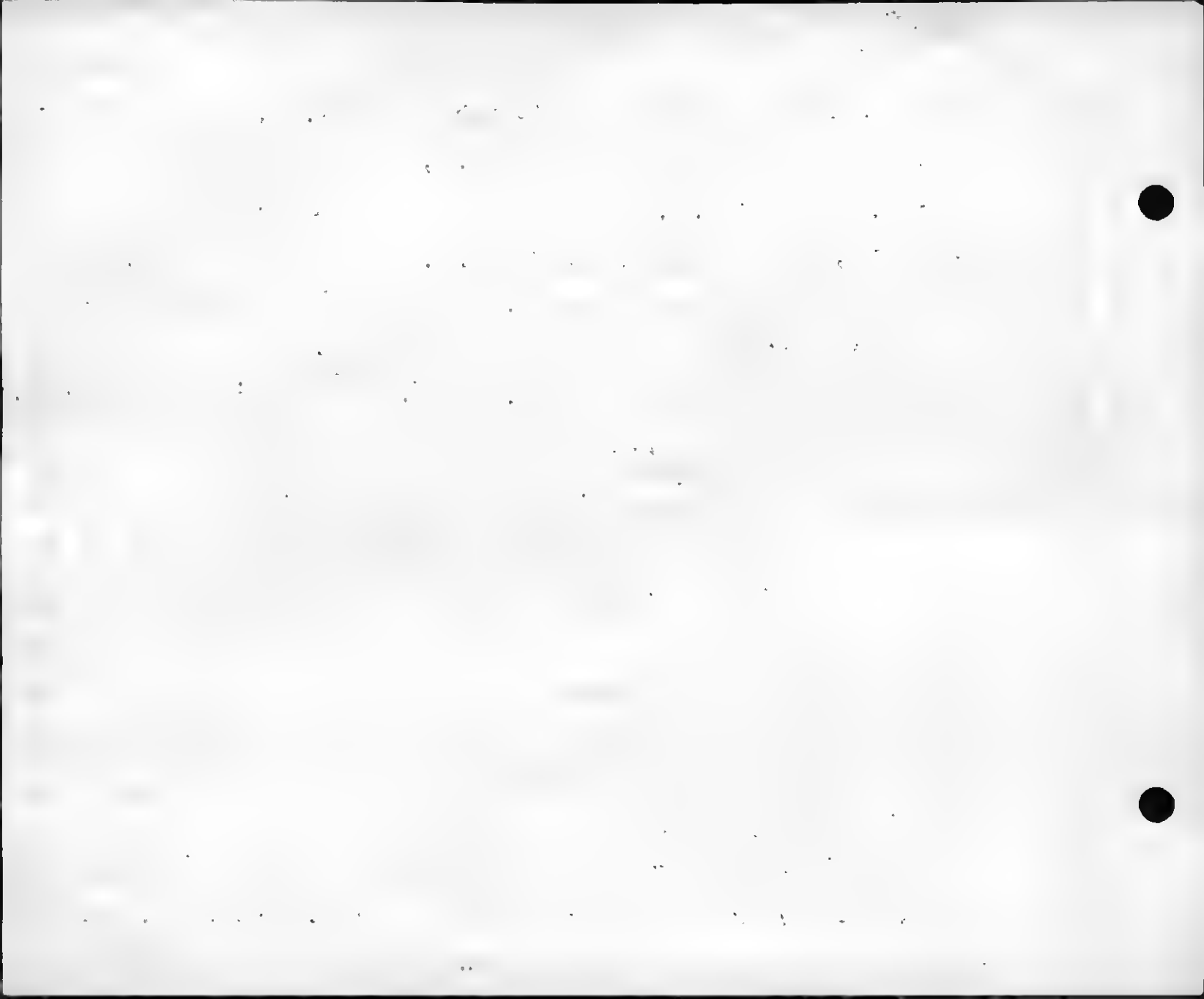
| | | | | | | | | | | | |
|---|---------|-----------------|--|----------------|------|---|-----|--------------------------|--|--|----------|
| 1 DECEASED NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH ESTIMATED | | | 2b. HOUR | | |
| MARION EDWARD SCOTT | | | | | | Month Day Year | | | 21 1968 7:37 | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (In years last birthday) | 7 UNDER 1 YEAR | | 7 UNDER 24 HRS | | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR |
| Male | Colored | 6-17-1945 | 22 YRS | MONTHS | DAYS | HOURS | MIN | Month Day Year | | | 7:37M |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 COUNTY OF DEATH | | |
| Sparks., Md. | | | U.S.A. | | | | | | Balto. Md. | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Balto. | | | St. Joseph Hospital | | | None | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institutional - Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| Md. | | | | | | Balto. | | | 5106 Craig Avenue | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | |
| UNK. | | | MARION SCOTT OAKLEY | | | NO | | | | | |
| 17. INFORMANT | | | ADDRESS | | | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| Mrs. Marion S. Oakley | | | 5106 Craig Ave | | | PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxia | | | | | |
| | | | | | | 916 X DUE TO, OR AS A CONSEQUENCE OF Compression of trachea | | | | | |
| | | | | | | Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | |
| | | | | | | (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| | | | | | | (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| | | | ? P.M. 2 21 19 68 | | | Jack slipped and car fell on subject | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | |
| | | | XXX St. | | | Western Run Rd. Cockeysville Balto. Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | EXAMINER'S NAME (Type) | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED | | |
| Edward F. Wilson | | | Edward F. Wilson, M.D. | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | XXX Feb. 22, 1968 | | |
| DEPUTY MEDICAL EXAMINER | | | ADDRESS | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | ADDRESS (Street, city, town, or county) | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATED IN (City or Town) (County) (State) | | |
| Burial | | | 2-25-68 | | | Union Chapel Cem. | | | Northern Balto. Co., Md. | | |
| 24. FUNERAL DIRECTOR | | | | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | |
| MORTON & DYETT F.H. 1701 Laurens St. | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | |
| | | | | | | DATE FEB 23 1968 | | | Charles Judge | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>12346</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>Item 5 Film G398 2/28/68 kkk</div> <div>CERTIFICATE OF DEATH</div> <div>234</div> | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1 DECEASED-NAME (Type or print) First Middle Last
Aline Cales Seccomb | | | | | | 2a. DATE OF DEATH Month Day Year
Feb. 23, 1968 | | | 2b. HOUR
3:15 P.M. | | |
| 3. SEX
Female | | 4 RACE
White | | 5 DATE OF BIRTH
Mar. 4, 1892/ 1891 | | 6 AGE (In years last birthday)
76 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
Penna. | | 7b. CIT ZEN OF WHAT COUNTRY?
U. S. A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH
Baltimore, County Md | | | | | |
| 10 CITY OR TOWN OF DEATH
Catonsville, | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
House in the Pines N. H. | | | 12a. USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired)
Housewife | | | 12b. K ND OF BUSINESS OR INDUSTRY
Own Home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Camp Springs, Md. | | | 13c. CITY OR TOWN
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. INSIDE CITY LIM. 152 | | 13e. STREET AND NUMBER
7345 Chesterfield Drive | |
| 14 FATHER'S NAME First Middle Last
Sheridan Coles | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Nora Stacey | | | | 17 INFORMANT Address
Washington D. C. 20031
Col. M. L. Seccomb 7345 Chesterfield Dr. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)
NO | | | | 16b. SOCIAL SECURITY NO | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Myocardial Decompensation
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerotic Cardio-Vascular Disease
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4221 | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 week
10 yrs | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Chronic Brain Syndrome | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-19-1965 to 2-23-1968 , that (I) (we) last saw the deceased alive on 2-23-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Wilmer K. Gallagher M.D. | | | | DEGREE
M.D. | | ATTENDING PHYS.
<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
2-23-68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Wilmer K. Gallagher, M.D. | | | | 22e. ADDRESS
6209 Frederick Ave, Balt, Md. 21228 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Transportation | | 23b. DATE
2/24/1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Prospect Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Mansfield Tioga Co. Penna. | | | | | |
| 24 FUNERAL DIRECTOR
Eastern Funeral Home | | | | ADDRESS
Catonsville, Md. | | 25a. REGD. BY REGISTRAR
F-526 1958 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 3 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

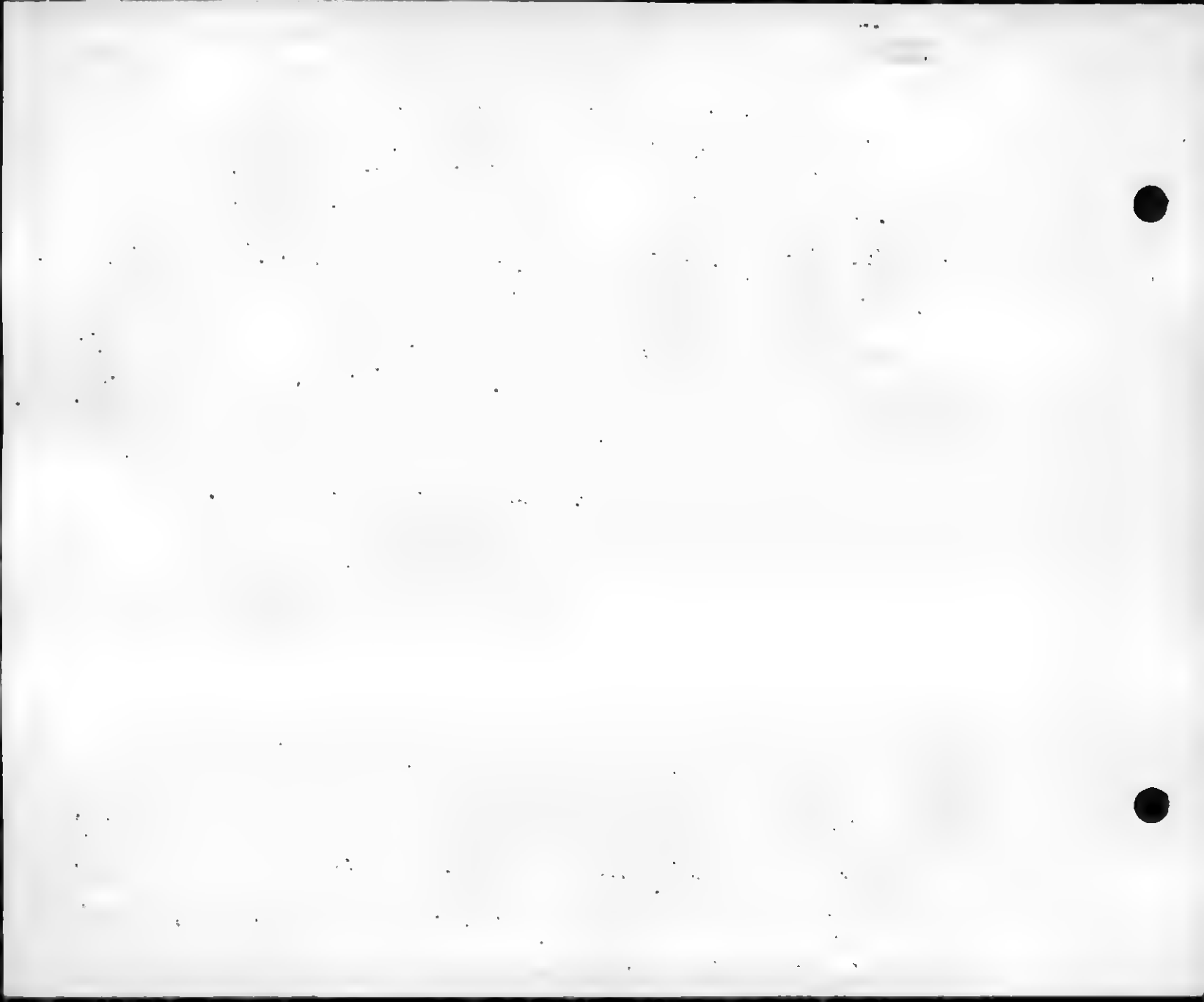
VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02347

02335

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) <i>ESTHER PRITCHARD S. WILSON</i> | | | 2a. DATE OF DEATH
Month <i>2</i> Day <i>11</i> Year <i>1968</i> | | | 2b. HOUR
<i>1:30 PM</i> | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>August 16, 1907</i> | | 6. AGE (In years last birthday)
<i>60</i> YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
<i>MICHIGAN</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>CATTINUS</i> Md. | |
| 10. CITY OR TOWN OF DEATH
<i>PARK TOWN</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>St. Luke's - Park</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
<i>None</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>None</i> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>MARYLAND</i> | | 13b. COUNTY
<i>PENNSYLVANIA</i> | | 13c. CITY OR TOWN
<i>Pennsylvanian</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER
<i>811 - PA.</i> | | 14. FATHER'S NAME First Middle Last
<i>(unknown)</i> | | 15. MOTHER'S MAIDEN NAME First Middle Last
<i>(unknown)</i> | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)
<i>NO</i> | |
| 16b. SOCIAL SECURITY NO.
<i>215-36-9</i> | | 17. INFORMANT
<i>Mrs. Elizabeth Truitt</i> | | Address
<i>301 W. Preston St. BALTIMORE</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>2-3 HOURS</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>UREMIA</i>
<i>4409</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>GENERALIZED ARTERIO-SCLEROSIS</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>CYAN.</i> | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5:00 P.M. 12, 1967</i> , to <i>4:00 P.M. 1968</i> , that (I) (we) last saw the deceased alive on <i>12-12-1967</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Edna Bryant, M.D.</i> | | DEGREE
<i>M.D.</i> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>2/11/68</i> | |
| 22d. PHYSICIAN'S NAME (Type)
<i>Edna Bryant, M.D.</i> | | 22e. ADDRESS
<i>824 Linden St. Baltimore, Md.</i> | | | | | |
| 23a. BURIAL, CREMATION, REINTERMENT (Specify) | | 23b. DATE
<i>2/14/68</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>St. Clare Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Randallstown Balt. Md.</i> | |
| 24. FUNERAL DIRECTOR
<i>Loring Byers</i> | | ADDRESS
<i>8728 Liberty Road</i> | | 25a. RECD BY REGISTRAR
DATE <i>FEB 13 1968</i> | | 25b. REGISTRAR'S SIGNATURE
<i>J. Lewis Judge</i> | |

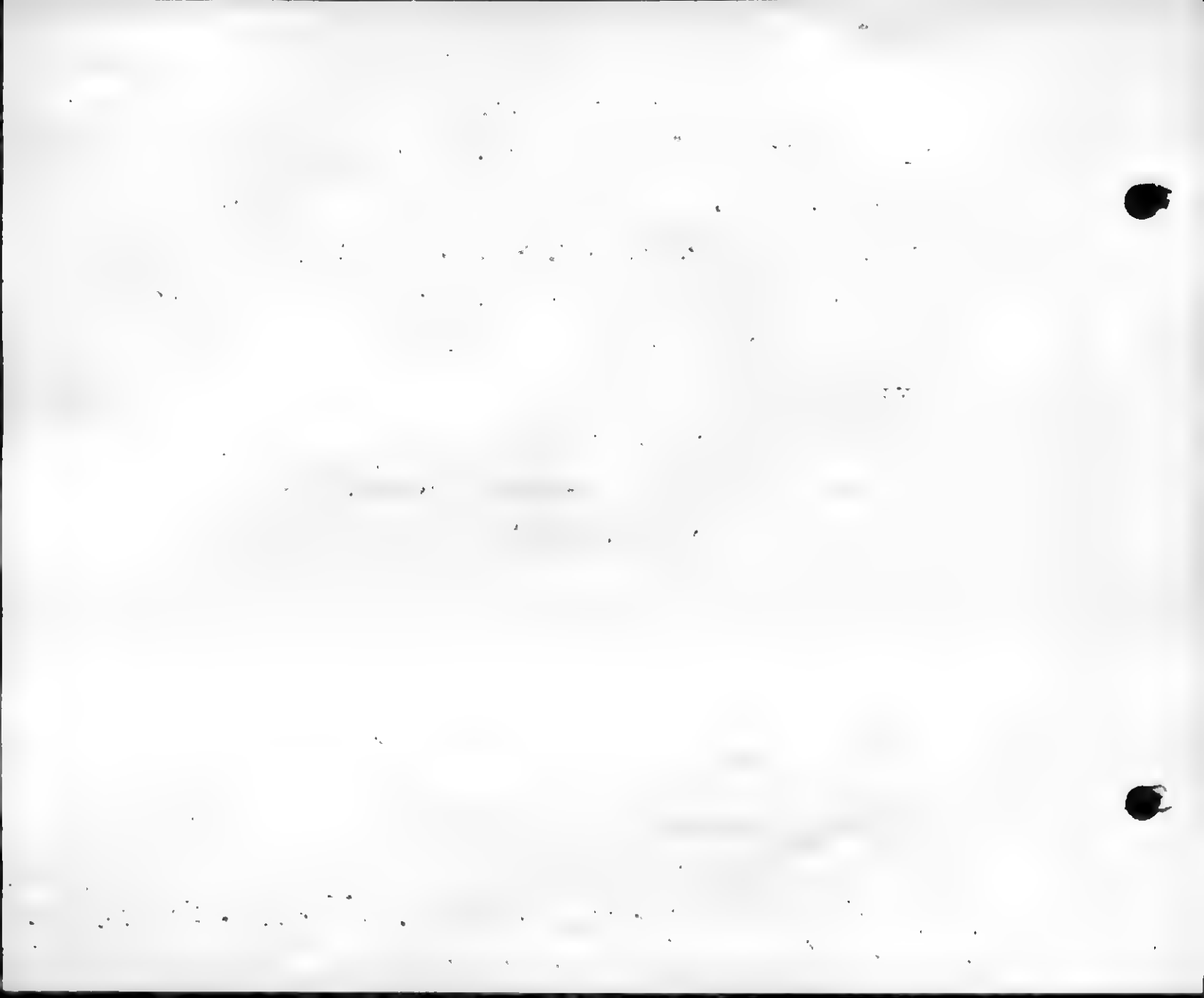


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|--|---|---|--|---|---|----------------------------------|-----------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| BLANCHE KATHERINE SEWELL | | | | | | Month 2 Day 4 Year 68 | | 11:50 AM | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (In years last birthday) | | IF UNDER 1 YEAR | | |
| FEMALE | | CAU | | 7-5-1901 | | 66 YRS. | | MONTHS DAYS HOURS MIN | | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | | |
| MARYLAND | | USA | | | | BALTIMORE | | Md. | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| BALTIMORE | | | GREATER BALT. MED. CENT | | | Housewife | | own home | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE | | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER | |
| MARYLAND | | | BALTIMORE | | BALTIMORE | | | | 117 SHERWOOD AVE | |
| 14 FATHER'S NAME First Middle Last | | | 15. MOTHER'S M A DEN NAME First Middle Last | | | | | | | |
| BENJAMIN LEONARD FORWARD | | | BERTHA VIOLA JUSTICE | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT Address | | | | | |
| UNKN | | | 214-20-6489 | | CHART | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | | | | |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Massive G.I. Bleeding | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (b) ASCVD - Congestive Heart failure | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) Diabetes mellitus | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/3, 1968, to 2/4, 1968, that (I) (we) last saw the deceased alive on 2/4 5:00 PM 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Parviz Navidi | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 2/4/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) Parviz Navidi | | | | | 22e. ADDRESS | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | | | | |
| Burial | | Feb. 7, 1968 | | Grace Valley Rd. Beltsville | | Beltsville Md. | | | | |
| 24 FUNERAL DIRECTOR | | | | | ADDRESS | | 25a. FILED BY REGISTRAR 1968 | | | |
| Frank H. Sewell | | | | | Beltsville Md. | | Charles Judge | | | |



FOR STATE
HEALTH DEPT.

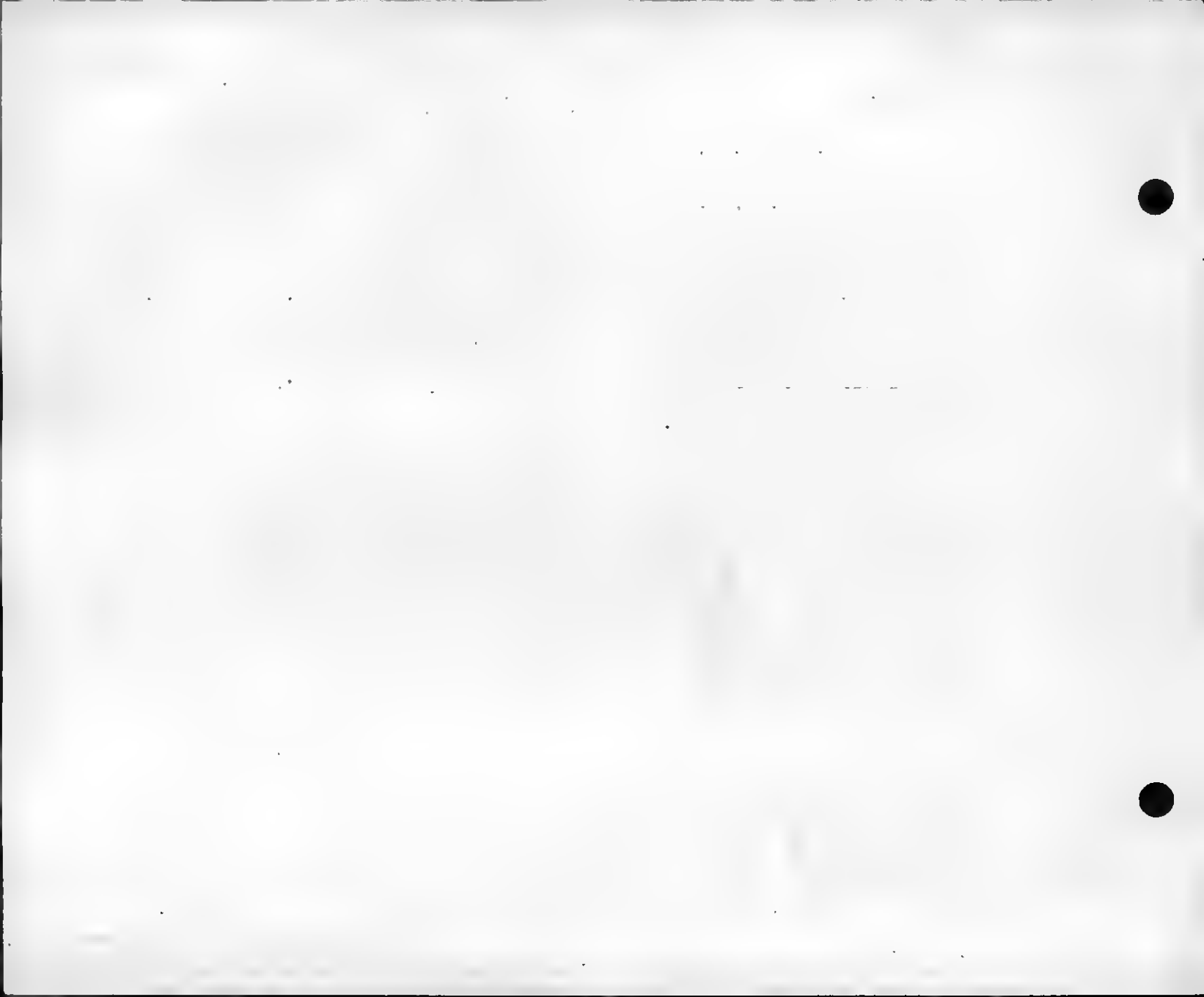
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MD-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

02349

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | |
|--|--|---|--|--|
| 1 DECEASED NAME
(Type or Print) MILDRED EVELYN SHAMBERGER | | 2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year Feb 19 1968 | | 2b HOUR 4P M |
| 3 SEX Female | 4 RACE Cau. | 5 DATE OF BIRTH Feb. 3, 1903 | 6 AGE (in years last birthday) 65 YRS | 7 UNDER 24 HRS <input type="checkbox"/> MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN |
| 7a BIRTHPLACE (State or foreign country) Maryland | 7b CITIZEN OF WHAT COUNTRY? U. S. A. | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 COUNTY OF DEATH Baltimore | |
| 10 CITY OR TOWN OF DEATH Parkton | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Carmel Road | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Secretary | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE Md. | 13b COUNTY Baltimore | 13c CITY OR TOWN Parkton | 13d WHOSE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | 13e STREET AND NUMBER Mt. Carmel Rd. |
| 14. FATHER'S NAME First Charles Middle Keys Last | | 15 MOTHER'S MAIDEN NAME First Clara Middle Britton Last | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16b SOCIAL SECURITY NO. 214-22-8952A | | 17. INFORMANT ADDRESS Thomas E. Shamberger, Same as # 13 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY OCCLUSION
1129
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) 65
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH: BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 7201 | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20 AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | 21b TIME OF INJURY Month, Day, Year 19 HOUR A.M. P.M. | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f LOCATION Street or R.F.D. No | City or Town | County State |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | |
| ACTUAL SIGNATURE A. M. France | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b DATE SIGNED 2/19/68 |
| EXAMINER'S NAME (Type) A. M. FRANCE | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| | | ADDRESS (Street, city, town, or county) | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b DATE Feb. 22, 1968 | 23c NAME OF CEMETERY OR CREMATORY Dulaney Valley | 23d LOCATION (City or Town) Cockeysville, Md. | (County) (State) |
| 24 FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road, Towson, Md. 21204 | | 25a REC'D BY REGISTRAR FEB 26 1968 | 25b REGISTRAR'S SIGNATURE J. Charles Judge | |

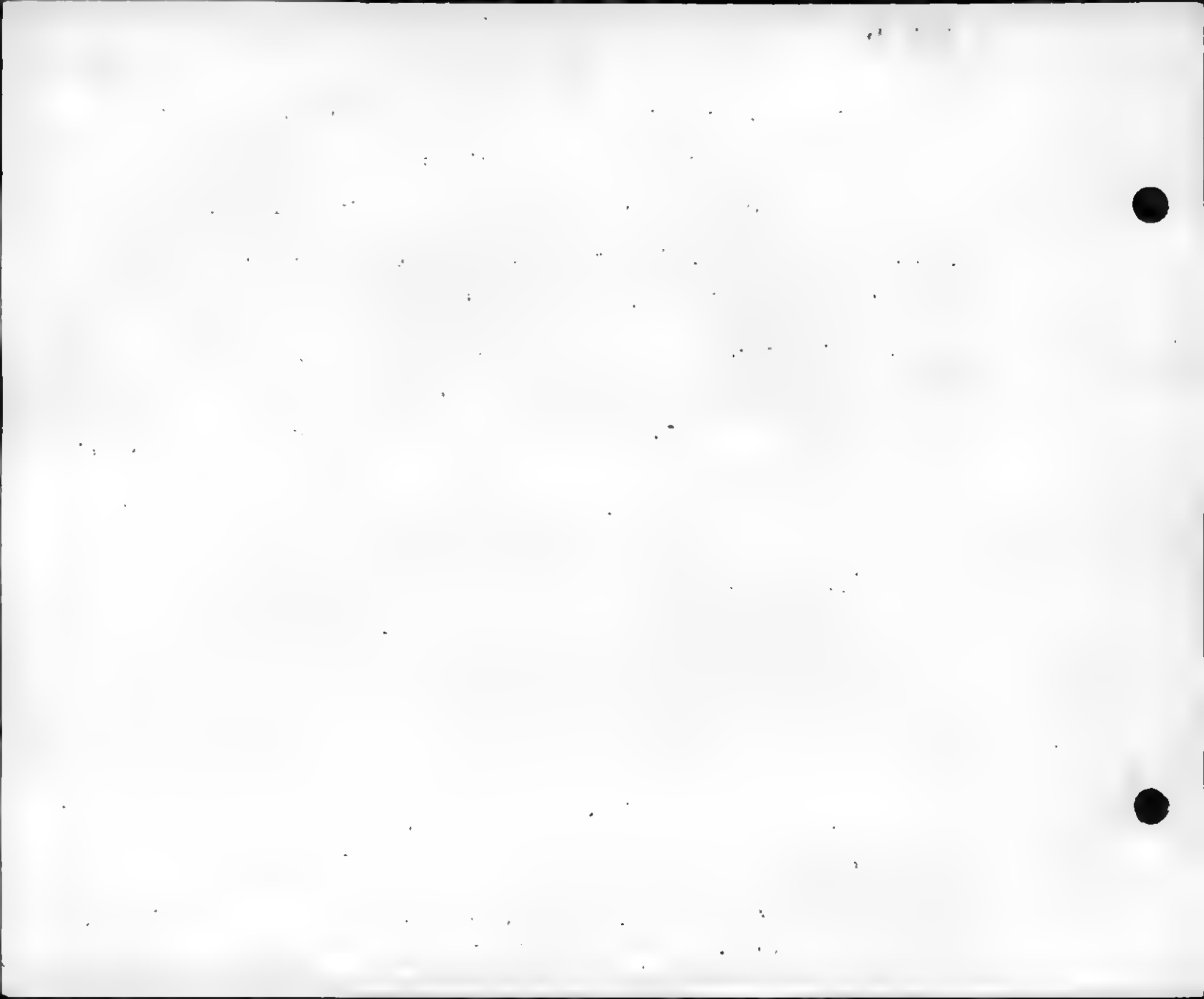


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

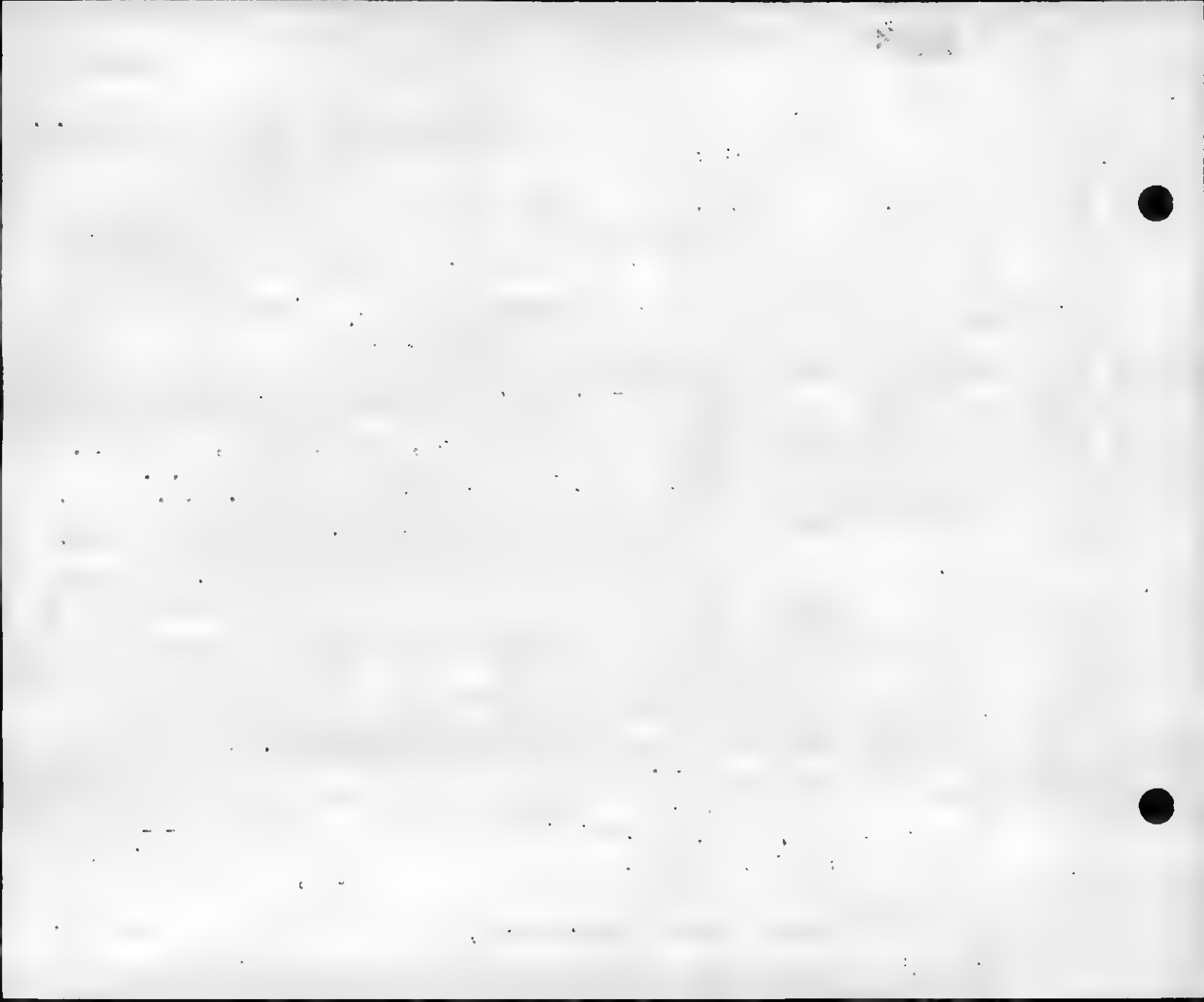
| <div style="display: flex; justify-content: space-between;"> 02330 MARYLAND STATE DEPARTMENT OF HEALTH 02338 </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 CERTIFICATE OF DEATH </div> | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|---|---|--|
| 1. DECEASED NAME (Type or print) First Middle Last
DENNIS C. SHANAHAN | | | | | | 2a. DATE OF DEATH
Feb. ^{Month} 28, ^{Day} 1968 Year | | | 2b. HOUR
M | | |
| 3 SEX
Male | | 4 RACE
white | | 5 DATE OF BIRTH
8/9/1904 | | 6 AGE (In years last birthday)
63 YRS | | 7. UNDER 1 YEAR
MONTHS DAYS | | 8. UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore County Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph's Hospital | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Chief Inspector | | | 12b. KIND OF BUSINESS OR INDUSTRY
Koppers Co. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Parkville | | 3d. INSIDE CITY - IN 1ST
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
2817 Onyx Road | | | |
| 14. FATHER'S NAME First Middle Last
Patrick Shanahan | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Ann E. McCarthy | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)
no | | 16b. SOCIAL SECURITY NO
213 01 5809 | | 17. INFORMANT
family Address | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART 1. DEATH WAS CAUSED BY.
1171 IMMEDIATE CAUSE (a) Systemic Lupus Erythematosus
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 456x
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Arteriosclerosis | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Darryl M. Robinson Jr. DEGREE | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2/29/68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
DARRYL M. ROBINSON JR. | | | | | | 22e. ADDRESS
1209 St Paul St | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
burial | | 23b. DATE
3/2/1968 | | 23c. NAME OF CEMETERY OR CREMATORY
St. John's, Long Green | | 23d. LOCATION (City or Town) (County) (State)
Balto. Md. | | | | | |
| 24. FUNERAL DIRECTOR
CHARLES F. EVANS & SON ADDRESS
8802 Harford Road | | | | | | 25a. REC'D BY REGISTRAR
DATE MAR 4 1968 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|--|--|------------------------------------|---|---|---|---|----------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1 DECEASED NAME (Type or print) | | | First | | Middle | | Last | | 2a DATE OF DEATH | | 2b HOUR |
| Lloyd | | | Monroe | | Shipley | | | | Month Day Year
February 6, 1968 | | 9:00 a.m. |
| 3 SEX | | | 4 RACE | | | 5 DATE OF BIRTH | | | 6 AGE (in years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS |
| male | | | white | | | 1884 4-13 | | | 83 YRS | | IF UNDER 24 HRS HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 COUNTY OF DEATH | | |
| Md. | | | U. S. | | | | | | Baltimore | | Md. |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Catonsville | | | SPRING GROVE STATE HOSP. | | | | | | Farmer | | Own |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md. | | | Balto. | | | Kingsville | | | | Shipley Road 21067 | |
| 14 FATHER'S NAME | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | |
| Benjamin Franklin | | | | | | | Shipley | | Henrietta Oales | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO | | | 17. INFORMANT | | | Address | | |
| No | | | 218-14-1052 | | | Records: SPRING GROVE STATE HOSPITAL | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Myocardial Infarction, acute, death. | | | | | | | | | | | 1 hr. |
| DUE TO, OR AS A CONSEQUENCE OF with previous anteprethelial H.I. | | | | | | | | | | | |
| (b) Arteriosclerotic Cardiovascular H. Dis. | | | | | | | | | | | 3 yrs. |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) Arteriosclerosis, Generalized, senile. | | | | | | | | | | | 17 yrs. |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| Decubitus ulcers; chronic brain syndrome asso. with arteriosclerosis | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from July 8, 1966, to Feb. 6, 1968, that I (we) last saw the deceased alive on Feb. 6, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | 22c. DATE SIGNED | | |
| Anthony J. Young, M.D. | | | | | | | | | 2-6-68 | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | 22e. ADDRESS | | |
| Anthony J. Young, M.D. | | | | | | | | | SPRING GROVE STATE HOSPITAL
Baltimore, Maryland 21228 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | | 2-10-1968 | | Baltimore Cemetery | | | Baltimore City Md. | | | |
| 24. FUNERAL DIRECTOR | | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Sassah General Home 7401 Belair Road | | | | | | 36 | | DATE FEB 9 1968 | | | |



FOR STATE
HEALTH DEPT.

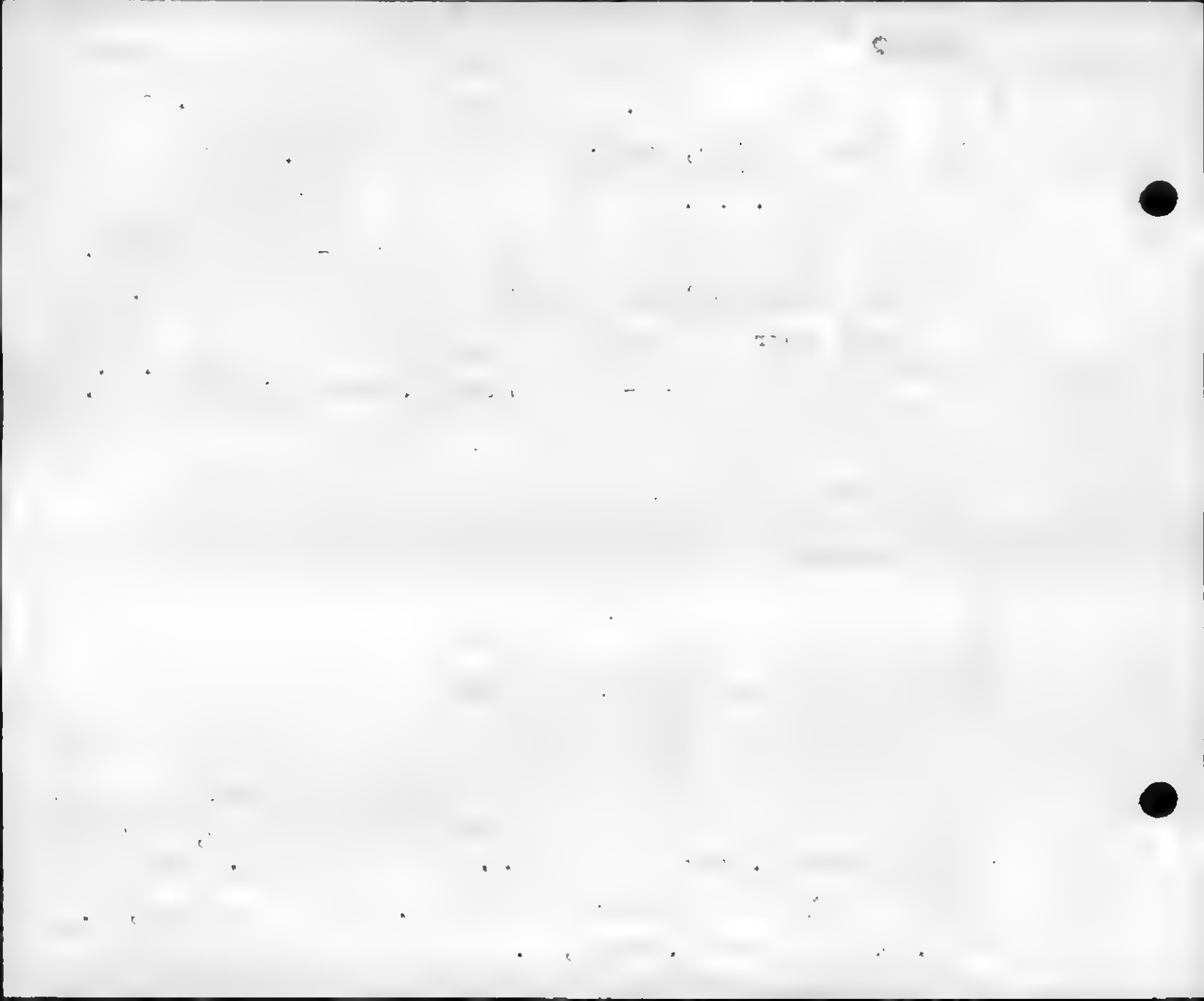
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

32352

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | |
|---|--------|---|--------------------------------|--|--|---|--|
| 1 DECEASED NAME
(Type or Print) | | First | Middle | Last | 2a DATE KNOWN OF DEATH
Month Day Year | | 2b HOUR |
| Joseph | | J. | Siebert | | Feb. 3 1968 | | 7:00 AM |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (In years last birthday) | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS
HOURS MIN | 2c DATE PRONOUNCED DEAD
Month Day Year | 2d HOUR |
| Male | White | March 21, 1889 | 78 YRS | | | Feb. 3 1968 | 8:00 AM |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
W DOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH | |
| Pennsylvania | | U. S. A. | | | | Baltimore Md. | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| Edgemere | | 7316 Bay Front Road | | Foreman- Bethlehem Steel Co. | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| Maryland | | Baltimore | | Edgemere | | 2201 Lincoln Ave. | |
| 14 FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b SOCIAL SECURITY NO | |
| Joseph | | Barbara Fuger | | Yes | | 213-07-8974 | |
| 16c | | 17 INFORMANT (Son) | | ADDRESS | | 18 | |
| | | Mr. James T. Siebert, 2213 Firethorn Rd. | | Balto. Md. | | | |
| 18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))
PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CH-S-C-V Disease</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>2. Scurvy</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20 AUTOPSY? | | | |
| | | None | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> | | 21b TIME OF INJURY Month, Day Year
HOUR A.M. P.M. | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e PLACE OF INJURY (At home, farm street, factory, office building, etc.) | | 21f LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER | | 6800 Mornington Road | | 22b DATE SIGNED | |
| EXAMINER'S NAME (Type) | | Melvin B. Davis M.D. | | Dundalk, Md. | | 2/3/68 | |
| 23a BURIAL CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | |
| Burial | | 2/7/68 | | Baltimore National Cem. | | Baltimore, Md. | |
| 24 FUNERAL DIRECTOR | | | | 25a REC'D BY REG. STR. | | 25b REGISTRAR'S SIGNATURE | |
| John J. Duda, 7922 Wise Ave. Dundalk, Md. | | | | FEB 9 1968 | | | |

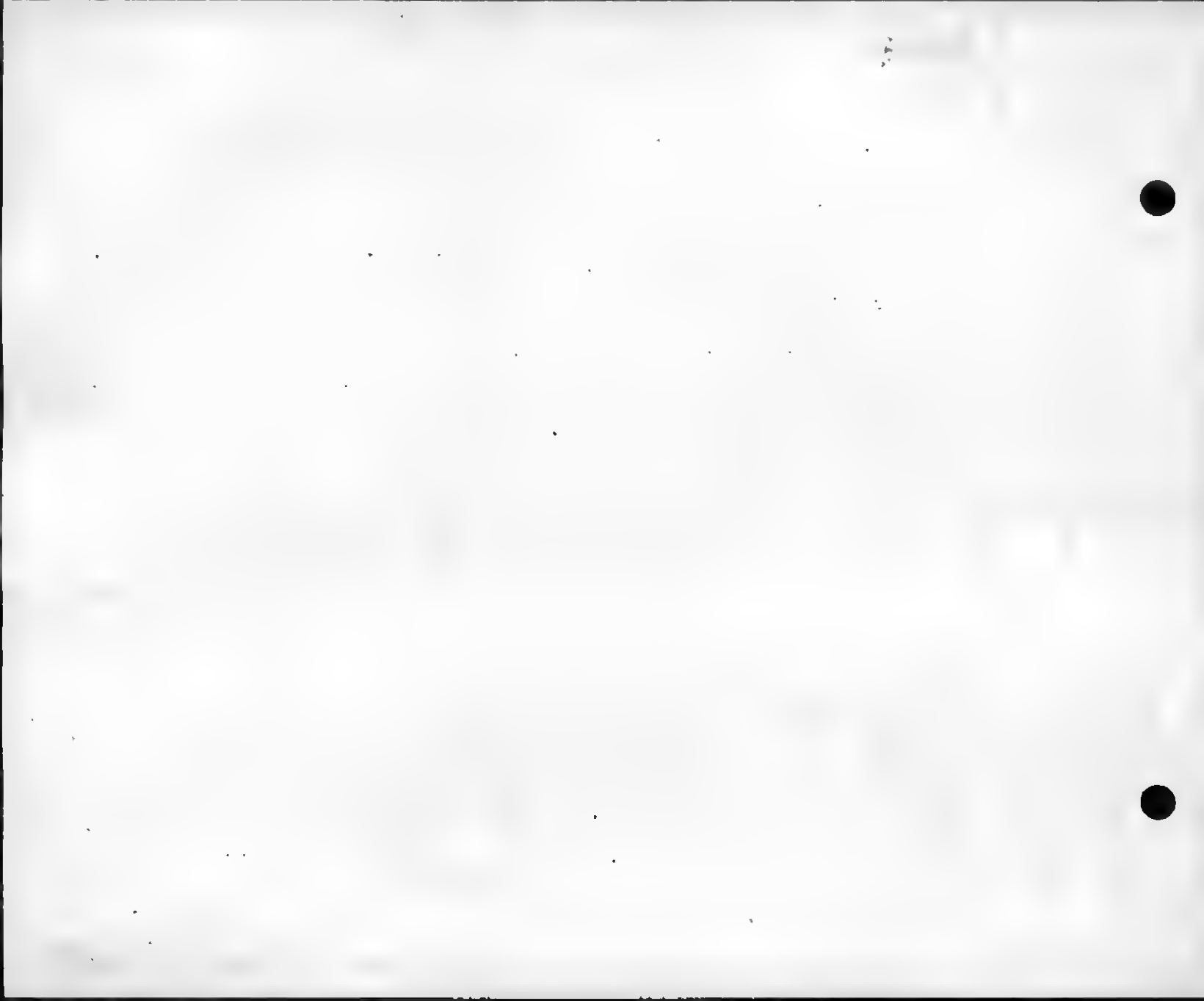


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

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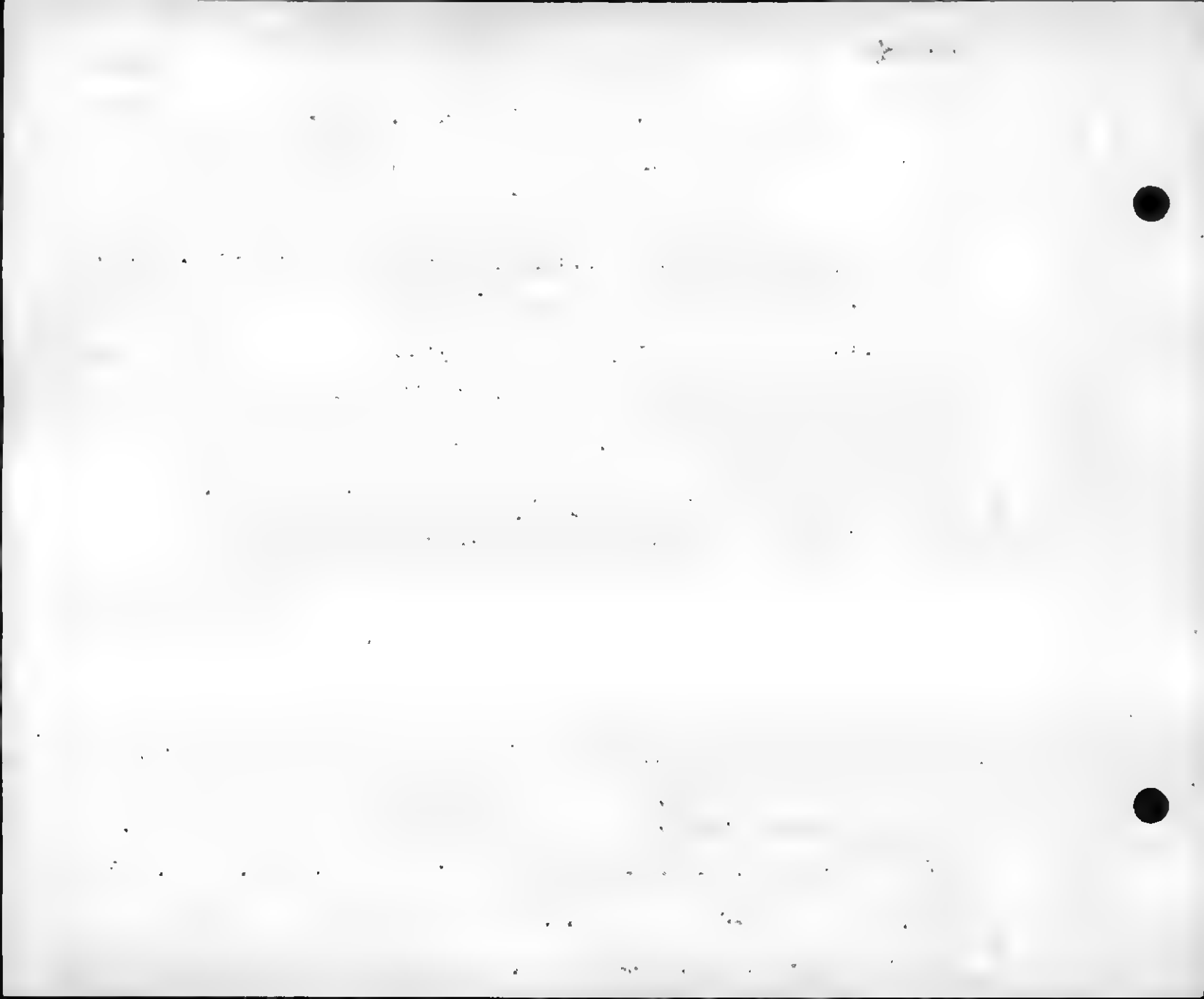
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
|---|-----------------|--|---|---|--|---|---|--|--|---|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1 DECEASED NAME (Type or Print) JACK NEVIN SIGA FOOSE | | | | | | 2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> M <input type="checkbox"/> F Feb 17 1968 | | 2b HOJR M | | | | |
| 3 SEX M | 4 RACE W | 5 DATE OF BIRTH 12-21-26 | 6 AGE (in years last birthday) 41 YRS | 7 UNDER 1 YEAR MONTHS DAYS | 8 IF UNDER 24 HRS HOURS MIN | 2c DATE PRONOUNCED DEAD Feb 17 1968 | | 2d HOUR 11:17 AM | | | | |
| 7a BIRTHPLACE (State or foreign country) Ill. Mo. | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH BALTIMORE | | | | | | |
| 1d CITY OR TOWN OF DEATH Towson | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bosley Ave | | | 12a USIA. OCCUPATION (Kind of work done during most of working life, even if retired) Base Ten. Asst | | 12b KIND OF BUSINESS OR INDUSTRY Restaur. Asst | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md | | | 13b COUNTY Balto. | | 13c CITY OR TOWN Cockeysville | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER 8-1A Warren Lodge Ct. | | | |
| 14 FATHER'S NAME First HARRY E. Middle Sigafoose Last | | | | | | 15. MOTHER'S MAIDEN NAME First Kittie E. Middle BRANDT Last | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES | | | 16b SOCIAL SECURITY NO 212-228040 | | 17 INFORMANT Mrs Rita B. Sigafoose - James 13 | | ADDRESS | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARBON MONOXIDE
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Hr. | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 9131 | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b TIME OF INJURY Month, Day, Year 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | |
| 22a INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> OR NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f LOCATION Street or R.F.D. No | | City or Town | | County | | State | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | |
| ACTUAL SIGNATURE William A. Pillsbury | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b DATE SIGNED Feb 17 1968 | | |
| EXAMINER'S NAME (Type) WILLIAM A. PILLSBURY | | ADDRESS (Street, City, Town or County) Towson, Md | | ADDRESS (Street, City, Town or County) | | | | | | | | |
| 23a BURIAL (CREMATION, REMOVAL) (Specify) BURIAL | | 23b DATE Feb 19 1968 | | 23c NAME OF CEMETERY OR CREMATORY LORRAINE | | 23d LOCATION (City or Town) Wooten | | (County) Md | | (State) | | |
| 24 FUNERAL DIRECTOR WM Cook Brook Towson | | ADDRESS 1050 York Rd Towson, Md 21204 | | 25a REC'D BY REGISTRAR FEB 20 1968 | | 25b REGISTRAR'S SIGNATURE Charles Jones | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--------|--|--|--|---|---|--|-----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| Charles G. Sillaman, Sr. | | | | | | Feb. 4, 1968 | | | 3 M |
| 3 SEX | 4 RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | |
| Male | White | | 13 April 1910 | | | 57 YRS | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Virginia | | USA | | | | Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Catonsville | | | Forest Haven Nursing Home | | | Ironworker - Ret. | | Shipyard | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER |
| Md. | | | AA | | Cambrills | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| David Sillaman | | | Elizabeth Farlow | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT Address | | | | |
| no | | | | | Gladys Sillaman, same as 13 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>PERSONAL UNUSUAL ACCIDENT</u>
<u>415</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>PROXIMAL SEVERE CARNIUM-UNUSUAL</u>
DUE TO, OR AS A CONSEQUENCE OF <u>DISAST</u>
(c) <u>MULTIPLY CAUSED-UNUSUAL</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/27, 1967</u> to <u>2/4, 1968</u> , that (I) (we) last saw the deceased alive on <u>1/31/68</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>John H. Shaw, M.D.</u> | | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
5 Feb. 68 | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | 22e. ADDRESS | | | | |
| John H. Shaw, M.D. | | | | | 5800 Edmondson Ave. Balto. 21226 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 6 Feb. 68 | | Glen Haven Memorial Park | | Glen Burnie, Maryland | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Arkley Funeral Home, Glen Burnie, Md. | | | | | DATE FEB 7 1968 | | <u>Charles J. Jones</u> | | |

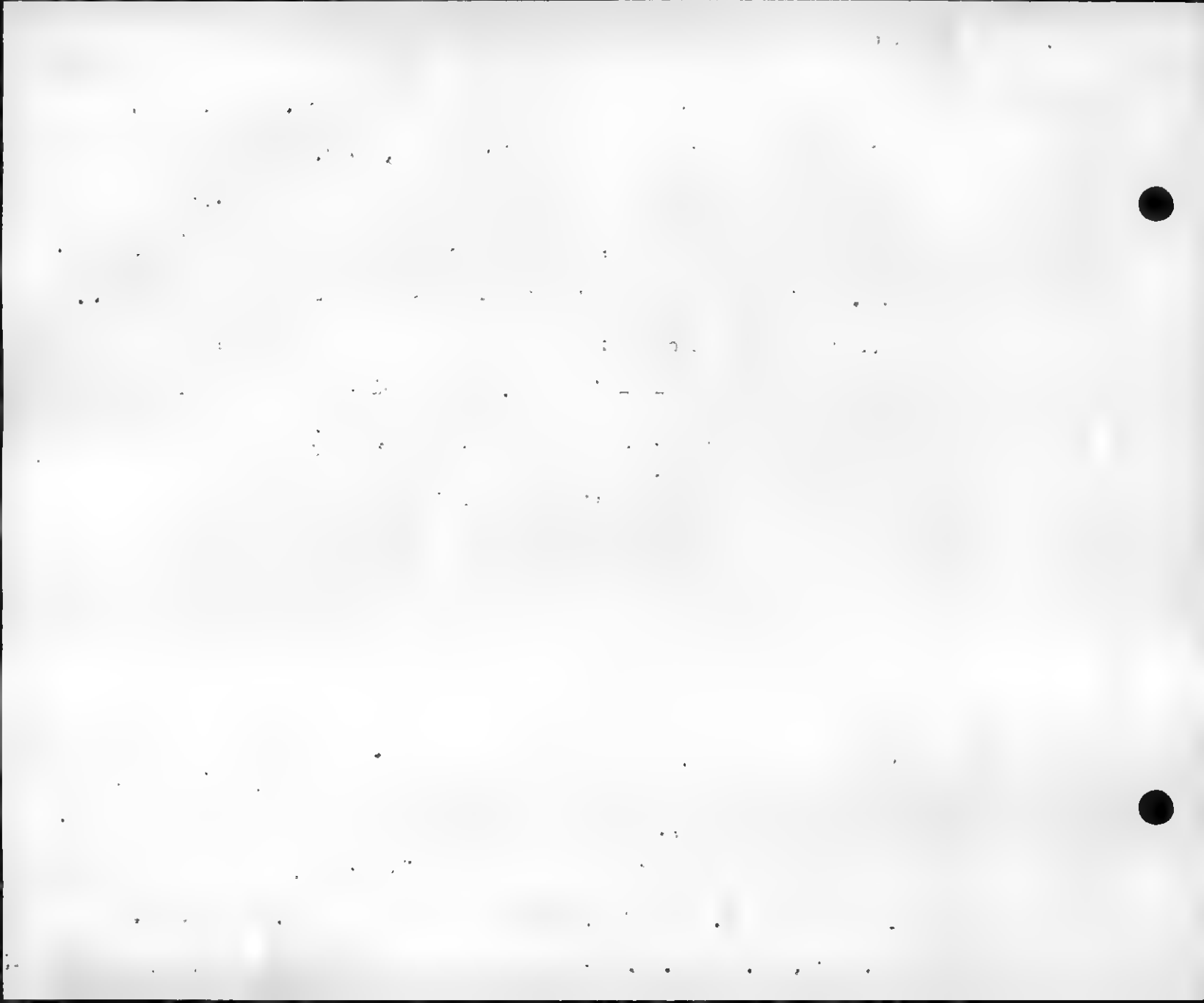


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VR A111 (4)
30A REV 1/68

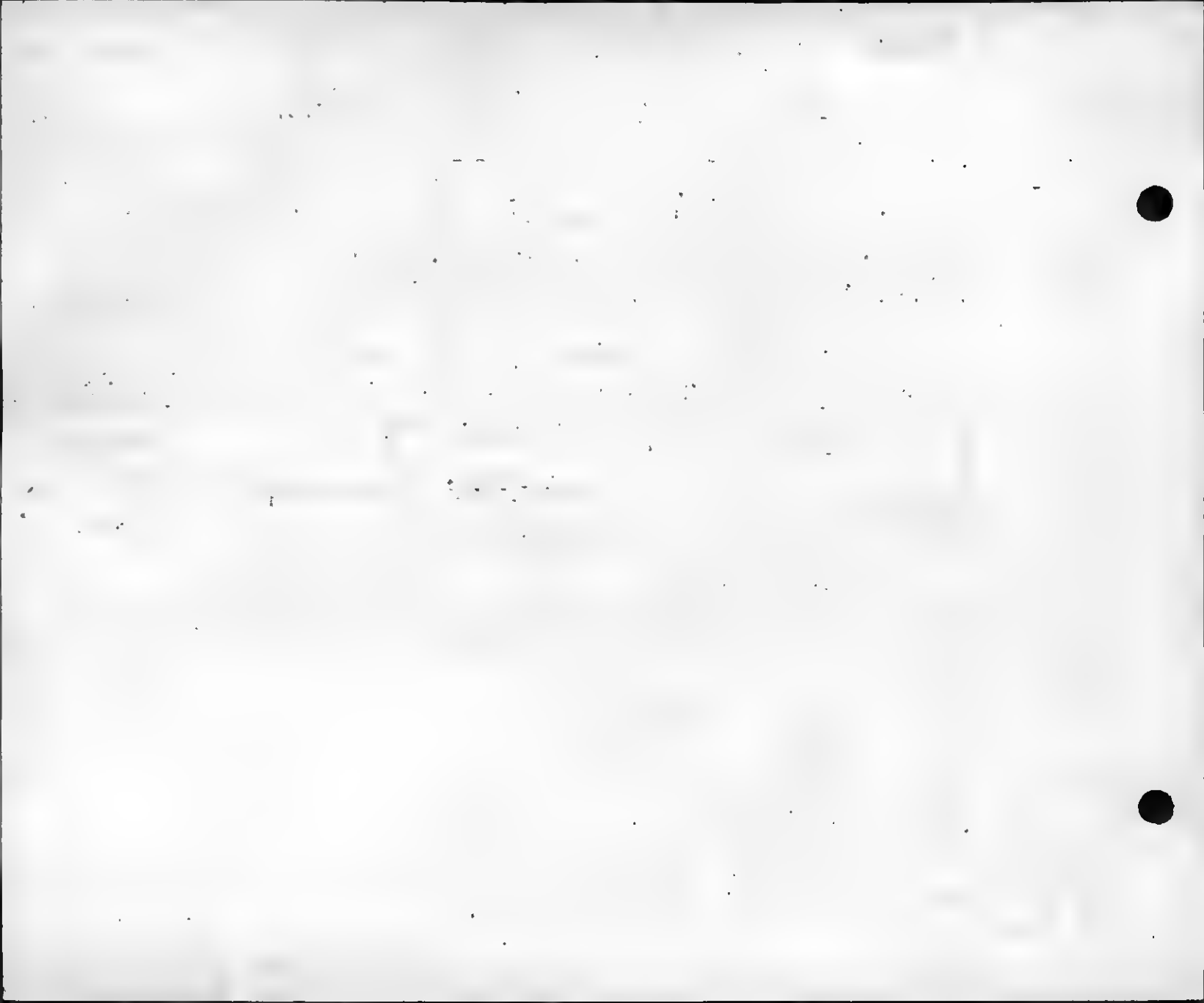
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|---|--|---|--|--|--|---|--|--|--|---|
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1 DECEASED NAME
(Type or print) | | First
LOIS | | Middle
MAE | | Last
SIMMONS | | 2a. DATE OF DEATH
Feb. Month 22, 1968 Year | | 2b. HOUR
M |
| 3 SEX
Female | | 4 RACE
White | | 5 DATE OF BIRTH
January 12, 1902. | | 6 AGE (In years
last birthday)
66 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | F UNDER 24 HRS
HOURS MIN |
| 7a. BIRTHPLACE (State or foreign
country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH
Baltimore Md | | | | |
| 10 CITY OR TOWN OF DEATH
Towson | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Chesapeake Manor Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired)
Owner | | 12b. KIND OF BUSINESS OR
INDUSTRY
Restaurant | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Md. | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
4503 Old Frederick Rd. | | |
| 14 FATHER'S NAME
Robert | | First
Middle
Bloodsworth | | Last
Unknown | | 15. MOTHER'S MAIDEN NAME First
Middle
Last | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) (If yes give war or dates of service)
No | | 16b. SOCIAL SECURITY NO.
219-03-6502 | | 17. INFORMANT
Mr. Raymond Simmons | | Address
(Same) | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Generalized Carcinomatosis | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) Carcinoma of Colon | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
15 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County | | State |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 19, 1967, to Feb 21, 1968, that (I) (we) last
saw the deceased alive on Feb 19, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. Feb 22, 1968 2-30 AM. | | | | | | | | | | |
| 22b. SIGNATURE
JAMSHID HAMED MD | | DEGREE | | ATTENDING
PHYS <input checked="" type="checkbox"/> | | MED.
DIRECTOR <input type="checkbox"/> | | STAFF
PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
Feb 22, 1968. |
| 22d. PHYSICIAN'S
NAME (Type)
JAMSHID HAMED. MD. | | 22e. ADDRESS
TOWSON 4, MD. | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
2/25/68. | | 23c. NAME OF CEMETERY OR CREMATORY
Asbury Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Mt. Vernon, Md. | | | | |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Balto. Md. 21214 | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE FFB 23 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|--|---|--|--|--|--|--|---|--|--|--|
| 1 DECEASED NAME (Type or print)
Clara | | First
E. | | Middle
Simpler | | Last | | 2a DATE OF DEATH
Month Feb. Day 20 Year 68 | | 2b HOUR
9:pm | |
| 3 SEX
Female | | 4 RACE
White | | 5 DATE OF BIRTH
3-1-90 | | 6 AGE (n years last birthday)
77 YRS. | | IF UNDER 1 YEAR
MONTHS 77 DAYS 77 | | IF UNDER 24 HRS
HOURS 77 MIN 77 | |
| 7a BIRTHPLACE (State or foreign country)
Md. | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH
Baltimore
Randallstown, Md. | | | | | |
| 10 CITY OR TOWN OF DEATH
Randallstown | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)
Balto. County Gen. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
CLERK | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if instituton on admision) STATE MD COUNTY BALTO | | 13b COUNTY BALTO | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER
3721 Courtleigh Drive | | | |
| 14 FATHER'S NAME First
Jerome | | Middle
Williams | | Last
Emma | | 15 MOTHER'S MAIDEN NAME First
Emma | | Middle
Dove | | Last
Dove | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b SOCIAL SECURITY NO
219-16-4962 | | 17 INFORMANT
Mrs. W. G. Simpler | | Address
3721 Courtleigh Drive, Randallstown, Md. | | | | | |
| 18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial insufficiency
4109
DUE TO, OR AS A CONSEQUENCE OF CONGESTIVE HEART FAILURE
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last ASCVD
DUE TO, OR AS A CONSEQUENCE OF Myocardial infarct (LV)
ASCVD | | | | | | | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Terminal
Weeks-days
Months-YRS | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Pulmonary atelectasis | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building etc) | | 21f LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE
GPACIB V. PATRICK | | | | | | | | | | 22c. DATE SIGNED
2/23/68 | |
| 22d. PHYSICIAN'S NAME (Type)
GPACIB V. PATRICK | | | | | | | | | | 22e ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
2/23/68 | | 23c. NAME OF CEMETERY OR CREMATORY
WOODLAWN | | 23d LOCATION (City or Town) (County) (State)
WOODLAWN, MD | | | | | |
| 24 FUNERAL DIRECTOR
Loring Byers - 8728 Liberty Road | | | | | | 25a. REC'D BY REG STRAR
DATE FEB 23 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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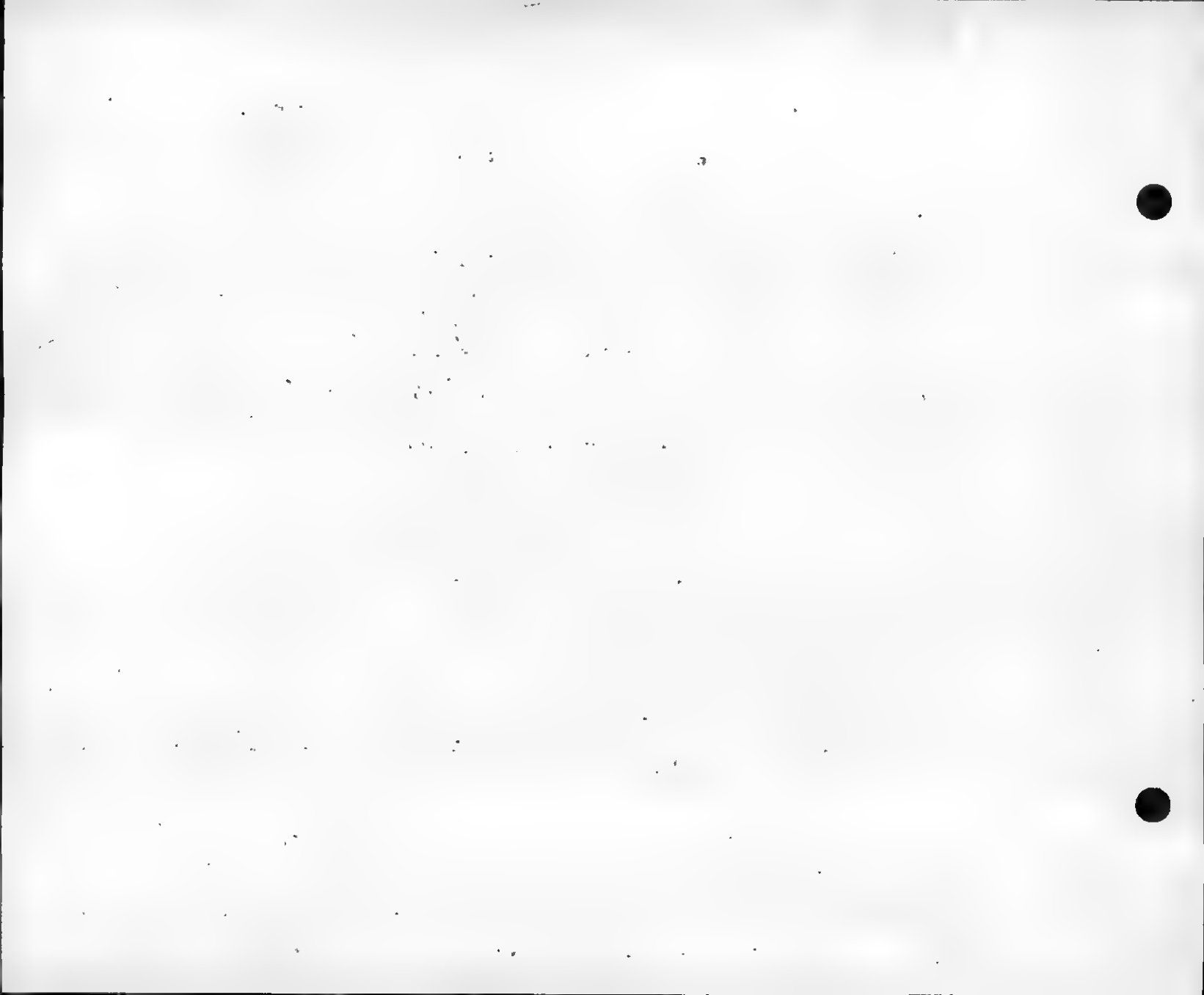
| 02357 | | | | | | | | | | 02345 | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1 DECEASED-NAME (Type or print) <u>Smith - Baby Boy</u> | | | | | | | | | | 2a. DATE OF DEATH
Month <u>2</u> Day <u>5</u> Year <u>1968</u> | | | | | | | | | |
| 3 SEX <u>Male</u> | | | | | | | | | | 2b. HOUR <u>11:25 AM</u> | | | | | | | | | |
| 4. RACE <u>Caucasian</u> | | | | | | | | | | 5 DATE OF BIRTH <u>Feb 5, 1968</u> | | | | | | | | | |
| 6 AGE (In years last birthday) <u>9</u> YRS | | | | | | | | | | 7 IF UNDER 1 YEAR MONTHS <u>9</u> DAYS <u>56</u> | | | | | | | | | |
| 7a BIRTHPLACE (State or foreign country) <u>MD.</u> | | | | | | | | | | 7b CIT ZEN OF WHAT COUNTRY? <u>U.S.A</u> | | | | | | | | | |
| 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH <u>BALTIMORE</u> Md | | | | | | | | | |
| 10 CITY OR TOWN OF DEATH <u>BALTIMORE</u> | | | | | | | | | | 11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>G B M C</u> | | | | | | | | | |
| 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | | | | | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <u>MD.</u> | | | | | | | | | | 13b. CITY OR TOWN <u>BALTO.</u> | | | | | | | | | |
| 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 13d STREET AND NUMBER <u>21212 1120 OVERBROOK Rd.</u> | | | | | | | | | |
| 14. FATHER'S NAME First <u>Paul</u> Middle <u>David</u> Last <u>Smith</u> | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First <u>Georgette</u> Middle <u>Ruth</u> Last <u>Beverungen</u> | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <u>Yes, no, or unknown</u> | | | | | | | | | | 16b. SOCIAL SECURITY NO. <u>—</u> | | | | | | | | | |
| 17 INFORMANT <u>MOTHER'S SHART</u> | | | | | | | | | | Address | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Immaturity</u>
<u>1/1/1 X</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>—</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>—</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 hours</u> | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS (CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a))
<u>1/16 X 30 weeks gestation</u> | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | |
| 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year <u>19</u> P.M. | | | | | | | | | |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.) | | | | | | | | | |
| 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-5-68 12:30 PM</u> to <u>2-5-68 1:30 PM</u> , that (I) (we) lost the deceased alive on <u>2-5-68</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>H. R. Dwyer, M.D.</u> | | | | | | | | | | 22c. DATE SIGNED <u>2-5-68</u> | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS <u>Johns Hopkins Med Center</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | 23b. DATE <u>2/9/68</u> | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>G B M C</u> | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) <u>Towson, Md. 21204</u> | | | | | | | | | |
| 24. FUNERAL DIRECTOR <u>John E. Adams</u> | | | | | | | | | | 25a. REC'D BY REGISTRAR <u>G B M C</u> | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE <u>John E. Adams</u> | | | | | | | | | | 25c. DATE <u>FEB 13 1968</u> | | | | | | | | | |



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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|---|--|--|--|--|--|--|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1 DECEASED-NAME
(Type or print) | | First
AUGUSTA | | Middle
VIRGINIA | | Last
SMITH | | 2a DATE OF DEATH
Month Day Year
February 2, 1968 | | 2b HOUR
11:40 AM |
| 3 SEX
Female | | 4 RACE
White | | 5 DATE OF BIRTH
October 9, 1882 | | 6 AGE (n years
ast birthday)
85 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN |
| 7a BIRTHPLACE (State or foreign
country)
Maryland | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore, Md | | | | |
| 10 CITY OR TOWN OF DEATH
Towson 4 | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
St. Joseph Hospital | | 12a USAL OCCUPATION (Kind of work done
during most of working life, even if retired)
At Home | | 12b. KIND OF BUSINESS OR
INDUSTRY
- | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution- Residence before
admission) STATE
Maryland | | 13b COUNTY
Baltimore | | 13c CITY OR TOWN
Baltimore | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
3616 Milford Avenue-21207 | | |
| 14. FATHER'S NAME First Middle Last
Priester | | 15 MOTHER'S MAIDEN NAME First Middle Last
UNKNOWN | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
No | | 16b. SOCIAL SECURITY NO.
- | | 17. INFORMANT Address
Helen S. Harden-2703 Beethoven Ave #7 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Pulmonary thromboembolism | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | |
| 21a ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State |
| 22a. I certify that (I) (this hospital) attended the deceased from February 2, 1968 to February 2, 1968, that (we) last
saw the deceased alive on February 2, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
William | | DEGREE | | ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
February 2, 1968 | | | | |
| 22d. PHYSICIAN'S
NAME (Type)
Ines Gilliani M.D. | | 22e ADDRESS
7620 York Road, Towson 4, Maryland | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
2-5-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt Olivet Cemetery | | 23d LOCATION (City or Town)
Balto. | | (County)
Md. | | (State) |
| 24 FUNERAL DIRECTOR
Elsworth Apmacost-4600 Lib. Heights Ave | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE
5 1968 | | 25b. REGISTRAR'S SIGNATURE
John Judge | | | | |

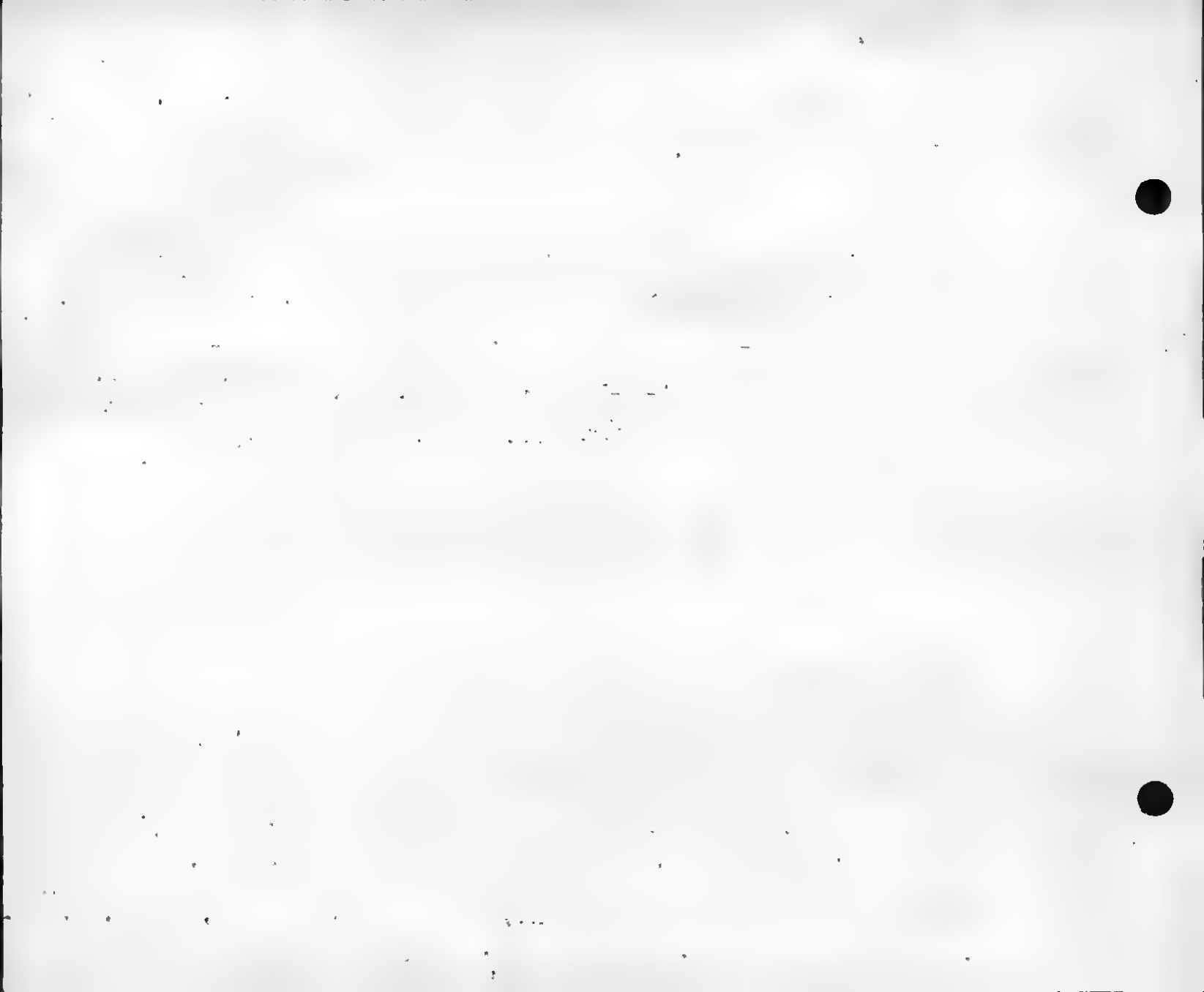


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) -
30M REV 1/68

| <div style="display: flex; justify-content: space-between;"> 02359 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02347 </div> <div style="text-align: center; font-weight: bold;">CERTIFICATE OF DEATH</div> | | | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|--|------------------------------------|---|
| 1 DECEASED-NAME
(Type or print) | | First | | Middle | | Last | | 2a DATE OF DEATH
Month <u>2</u> Day <u>25</u> Year <u>68</u> | | | 2b HOUR
<u>1 PM</u> |
| 3 SEX
<u>Female</u> | | 4 RACE
<u>White</u> | | 5 DATE OF BIRTH
<u>6/11/83</u> | | | 6 AGE (In years last birthday)
<u>84</u> YRS. | | 7 UNDER 1 YEAR
MONTHS <u> </u> DAYS <u> </u> | | IF UNDER 24 HRS.
HOURS <u> </u> MIN <u> </u> |
| 7a BIRTH-PLACE (State or foreign country)
<u>Maryland</u> | | 7b CITIZEN OF WHAT COUNTRY?
<u>United States</u> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<u>Baltimore</u> Md | | | | | |
| 10 CITY OR TOWN OF DEATH
<u>Lutherville</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<u>College Manor Nursing Home</u> | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
<u>Housewife</u> | | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>Own Home</u> | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE
<u>Maryland</u> | | 13b COUNTY
<u>Baltimore</u> | | 13c. CITY OR TOWN
<u>City</u> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<u>Apt. 3339 N Charles St.</u> | | | |
| 14 FATHER'S NAME | | First | | Middle | | Last | | 15 MOTHER'S MAIDEN NAME | | First Middle Last | |
| <u>Ferdinand</u> | | <u>-</u> | | <u>Focke</u> | | <u>Rachel</u> | | <u>-</u> | | <u>Lehman</u> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
<u>214-38-7356</u> | | 17. INFORMANT
<u>Louise Smith Cockey</u> | | Address
<u>1107 Charmuth Rd. Lutherville, Md. 21093</u> | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Atherosclerosis, generalized</u>
<u>4407</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u> </u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u> </u> | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. <u> </u> Month <u> </u> Day <u> </u> Year <u>19</u>
P.M. <u> </u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION
Street or R.F.D. No. <u> </u> City or Town <u> </u> County <u> </u> State <u> </u> | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1949</u> , to <u>Feb</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Feb 24</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>W. G. Helfrich MD</u> | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>2-26-68</u> | |
| 22d. PHYSICIAN'S NAME (Type)
<u>Dr. William G. Helfrich</u> | | 22e. ADDRESS
<u>5006 Roland Ave.</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE
<u>2/27/68</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Druid Ridge</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Pikesville, Balto. Co. Md.</u> | | | | | |
| 24. FUNERAL DIRECTOR
<u>H.W. Jenkins & Sons Co.</u> | | ADDRESS
<u>4905 York Rd. Balto. 12, Md.</u> | | 25a. REC'D BY REG. STRAR
DATE <u>FEB 26 1968</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | | | |

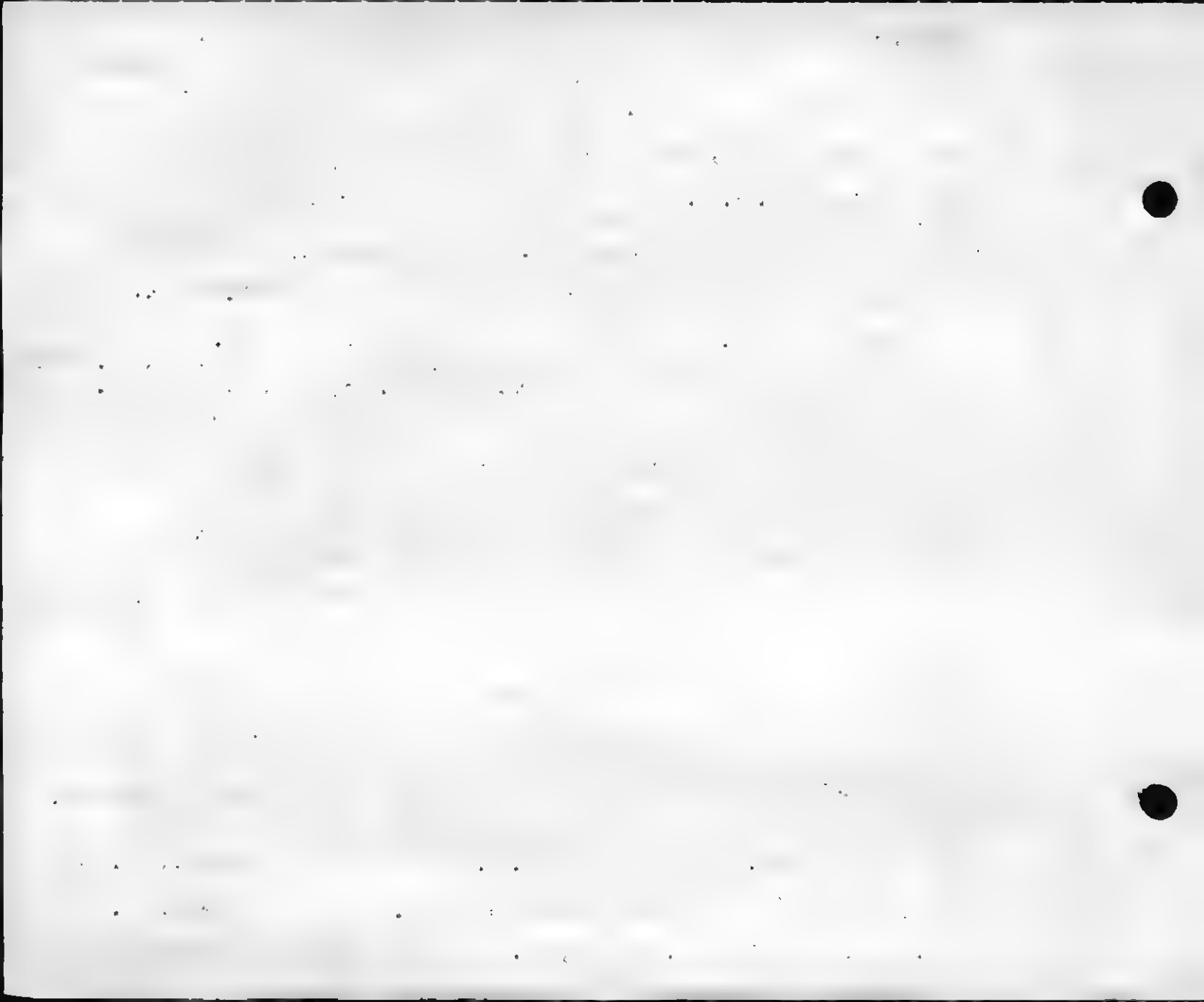


FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 1B. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--------|--|--|---|-----------------------|--|-----------------|---|-------------------------|---|---------|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1 DECEASED NAME
(Type or Print) | | First | | Middle | | Last | | 2a DATE KNOWN
OF ESTI-
DEATH MATED | | 2b HOUR | |
| Nannie | | A. | | Smith | | | | 2-27-1968 | | M | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | | 6 AGE (In years
last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 2c DATE PRONOUNCED DEAD | | 2d HOUR |
| Female | White | July 8, 1900 | | 67 YRS | MONTHS DAYS HOURS MIN | | | | 2-29-1968 | | 100 M |
| 7a BIRTHPLACE (State or foreign
country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | | Md | |
| West Virginia | | U. S. A. | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | Baltimore | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | | 12a USUAL OCCUPATION (Kind of work done
during most of working life, even if retired) | | 12b KIND OF BUSINESS OR
INDUSTRY | | | |
| Edgemere | | 2600 Brannan Ave. | | | | Housewife | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before
admission) STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | 13e STREET AND NUMBER | | | |
| Maryland | | Baltimore | | Edgemere | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 2600 Brannan Ave. | | | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | First Middle Last | |
| Thomas | | F. | | Martin | | | | Jennie | | V. ? | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO | | 17 INFORMANT (Daughter) | | ADDRESS | | Balto. Md. 21219 | | | |
| No | | 2/ | | Mrs. Myrtle L. Robinson, | | Waldman Ave. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) | | | | | | | | | | A-S-C-V-H disease | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. | | | | | | | | | | | |
| (b) | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION
WAS PERFORMED | | | | | | 20 ADJUSTED? | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a EXTERNAL CAUSE WAS
PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> | | 21b TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 1B) | | | | | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (At home, farm, street,
factory, office building, etc) | | 21f LOCATION Street or R.F.D. No | | City or Town | | County | | State | |
| 22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion
death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL
SIGNATURE | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> 6800 Morningside Rd. | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 22b DATE SIGNED | |
| EXAMINER'S
NAME (Type) | | Melvin B. Davis | | | | | | M. D. | | 3/1/68 | |
| 23a BURIAL CREMATION,
REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) | | (County) | | (State) | |
| Burial | | 3/4/67 | | Baltimore National Cem. | | Baltimore, Md. | | | | | |
| 24 FUNERAL DIRECTOR | | ADDRESS | | 25a REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | | | | |
| John J. Duda, 7922 Wise Ave. Dundalk, Md. | | | | MAR 4 1968 | | Charles Jones | | | | | |

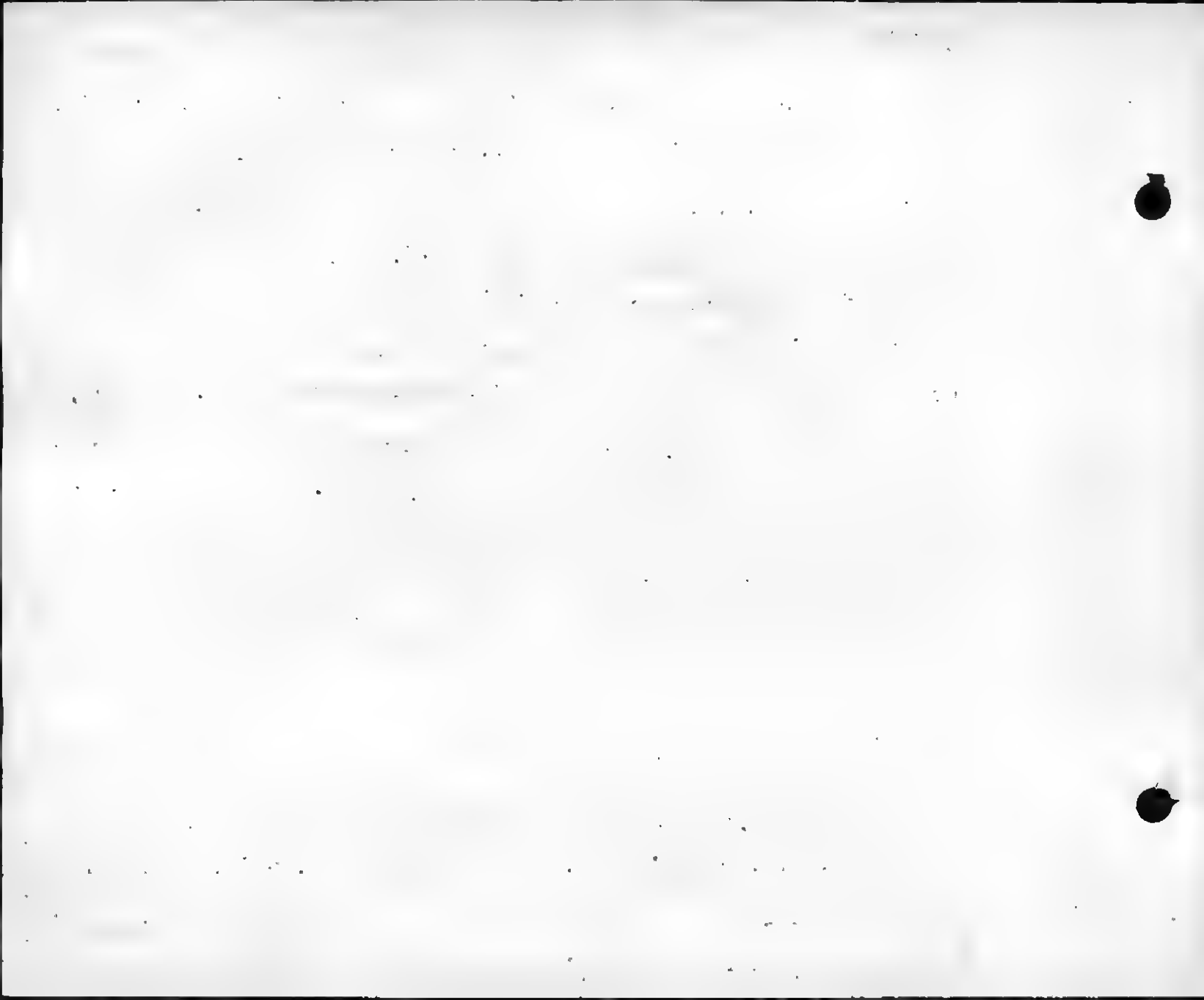


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 1-60
30M REV. 1-60

| MIDDLE | | | | | | | | | | | | |
|--|--|--|---|--|--|--|--|--|--|--|---|--|
| <div style="text-align: center;"> <p>32361</p> <p>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</p> <p>CERTIFICATE OF DEATH</p> </div> | | | | | | | | | | | | |
| 1. DECEASED NAME (Type or print) | | | First SARAH Middle ELIZABETH Last SPARKS | | | 2a. DATE OF DEATH FEBRUARY 28, 1968 | | | 2b. HOUR 12:05 AM | | | |
| 3 SEX Female | | | 4. RACE White | | | 5. DATE OF BIRTH December 31, 1884 | | | 6. AGE (In years last birthday) 83 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH Towson | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Presbyterian Home of Md. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) None | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE Maryland | | | 13b. COUNTY Baltimore | | | 13c. CITY OR TOWN Dundalk | | | 13d. INS. DE CITY L.M.T.S? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| 14. FATHER'S NAME First Middle Last John Wesley Sparks | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Mary Malvina Way | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, on () or unknown () No () (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address Presbyterian Home of Md. Towson, Md | | | | | | |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>CEREBRAL ARTERIOSCLEROSIS</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN 1960, to FEB 28, 1968, that (I) (we) last saw the deceased alive on FEB 21, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE Dr. S.J. Venable, Jr. M.D. | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED 2-28-68 | | | |
| 22d. PHYSICIAN'S NAME (Type) Dr. S.J. Venable, Jr. | | | | | | 22e. ADDRESS 7215 York Rd. Baltimore, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 3-1-68 | | | 23c. NAME OF CEMETERY OR CREMATORY Oaklawn | | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc. ADDRESS 6500 York Rd. Baltimore, Md. 21212 | | | | | | 25a. RECEIVED BY REGISTER FEB 29 1968 | | | 25b. REGISTER'S SIGNATURE | | | |

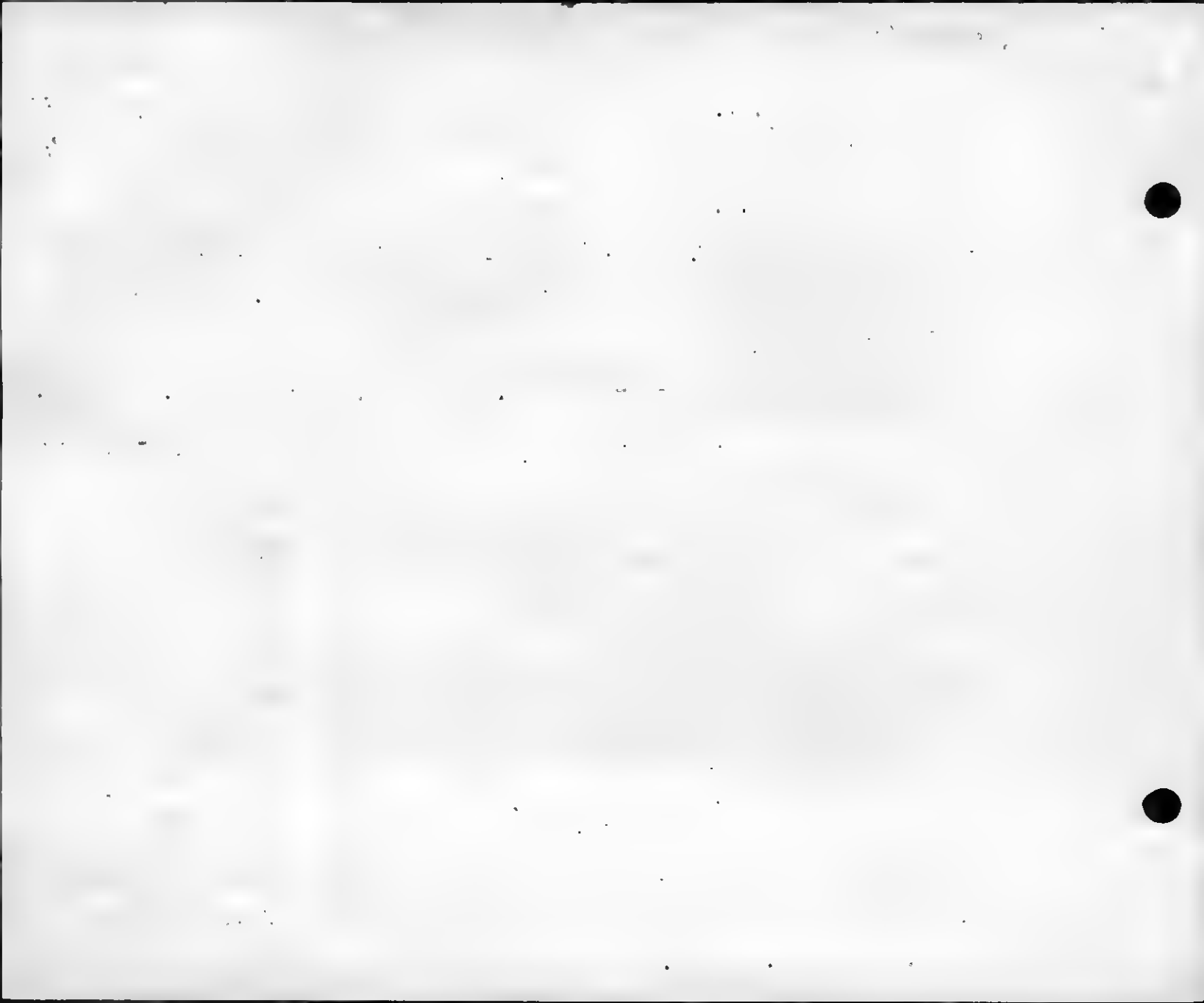


FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|--------|---|---|--|------|---|-----|---|---|--|---------|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1 DECEASED NAME
(Type or Print) | | | First Middle Last | | | 2a DATE KNOWN OF DEATH ESTIMATED | | | 2b HOUR | | |
| John M. B. Spilman | | | | | | 2/2/1968 | | | 8:30 AM | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (in years last birthday) | F UNDER YEAR | | IF UNDER 24 HRS | | 2c DATE PRONOUNCED DEAD | | 2d HOUR | |
| Male | White | 4/1/1902 | 65 YRS | MONTHS | DAYS | HOURS | MIN | 2 | Day | Year 1968 | 8:30 AM |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | 10a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | |
| Maryland | | U.S.A. | | | | Baltimore | | | Lighting salesman | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore County | | | St. Joseph's Hospital | | | Lighting salesman | | | Lighting | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution-Residence before admission) STATE | | | 13b COUNTY | | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS | | 13e STREET AND NUMBER | |
| Maryland | | | V | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 746 E. Lake Avenue | |
| 14 FATHER'S NAME First Middle Last | | | 15 MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | |
| Jeremiah Spilman | | | Alice Brooks | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) | | | 17. INFORMANT | | | ADDRESS | | |
| No | | | 215-09-8704 | | | Mrs. Margaret J. Spilman | | | 746 E. Lake Ave. | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion | | | | | | | | | | Evident | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 420 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| CAUSE OF DEATH | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County | | State | |
| AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from | | | | | | | | | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | EXAMINER'S NAME (Type) | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED | |
| Charles F. O'Donnell | | Charles F. O'Donnell | | | | | | | | 2/2/68 | |
| ADDRESS (Street, city, town, or county) | | | | | | | | | | | |
| | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | 2/5/1968 | | New Cathedral Cemetery | | Baltimore, Maryland | | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| John A. Moran Inc. | | | | 3000 E. Baltimore Street | | FEB 5 1968 | | J. Moran | | | |

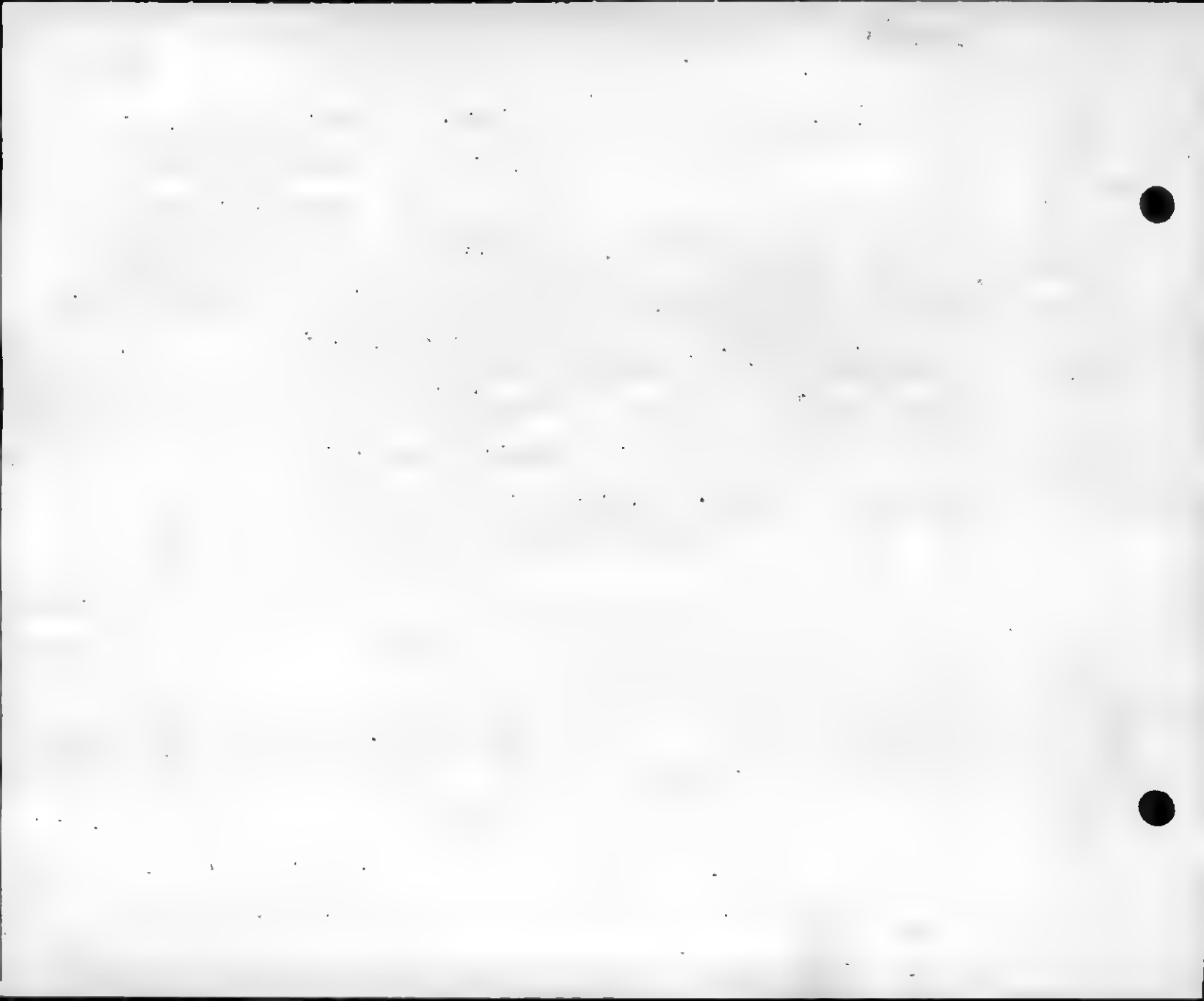


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

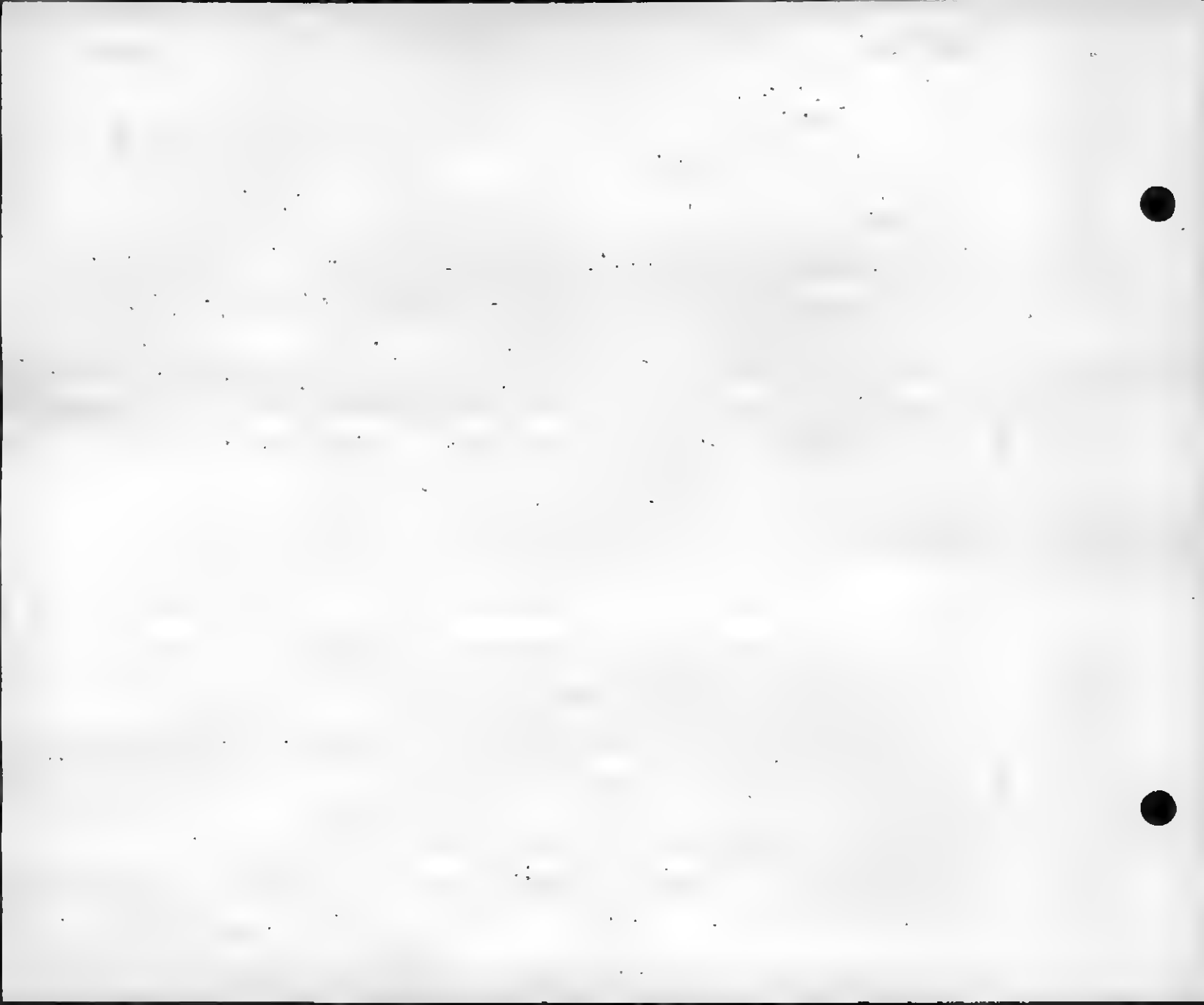
| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH | | | | | | | | | | | | | | | |
|---|--|---|--|--|--|---|--|----------------------------|--|-------------------------|--|---|--|---|--|
| 1 DECEASED-NAME
(Type or print) | | First | | Middle | | Last | | 2a. DATE OF DEATH
Month | | Day | | Year | | 2b. HOUR | |
| Marlin | | Starnes | | February | | 24 | | 1968 | | 8:55am | | | | | |
| 3 SEX | | 4. RACE | | 5 DATE OF BIRTH | | 6 AGE (in years
last birthday) | | 7. UNDER 1 YEAR
MONTHS | | 8. UNDER 24 HRS
DAYS | | 9. UNDER 24 HRS
HOURS | | 10. MIN. | |
| Male | | White | | September 6, 1922 | | 45 | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | | | | | | | |
| Pennsylvania | | U.S.A. | | | | Towson, Baltimore 4 | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | | | | | |
| Towson | | St. Joseph Hospital | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before
admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | | | | | | |
| Maryland | | Baltimore | | | | | | 2840 Louisiana Avenue-27 | | | | | | | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15 MOTHER'S MAIDEN NAME | | First | | Middle | | Last | |
| Oscar T Starnes | | | | | | | | Esta Dittenhafer | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown <input type="checkbox"/> | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT | | Address | | | | | | | | | |
| Yes | | WW II | | | | Family | | Same | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Chronic renal failure and severe anemia</u>
DUE TO, OR AS A CONSEQUENCE OF
<u>xxx with terminal heart failure</u>
DUE TO, OR AS A CONSEQUENCE OF
<u>(c)</u> | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that (a) (this hospital) attended the deceased from February 17, 1968, to February 24, 1968, that (b) (we) last saw the deceased alive on February 24, 1968, and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above. (d) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Ines Cilliani</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | | | | | | 22c. DATE SIGNED February 24, 1968 | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>Ines Cilliani, M.D.</u> | | | | | | | | | | | | 22e. ADDRESS <u>7620 York Road, Towson 4, Md.</u> | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | |
| Burial | | 2/27/68 | | Glen Haven Cem | | Glen Burnie AA Co Md | | | | | | | | | |
| 24. FUNERAL DIRECTOR <u>Mc Gully F.H. 737 + 4240 Ave</u> ADDRESS | | | | | | | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |
| | | | | | | | | | | | | DATE FEB 27 1968 | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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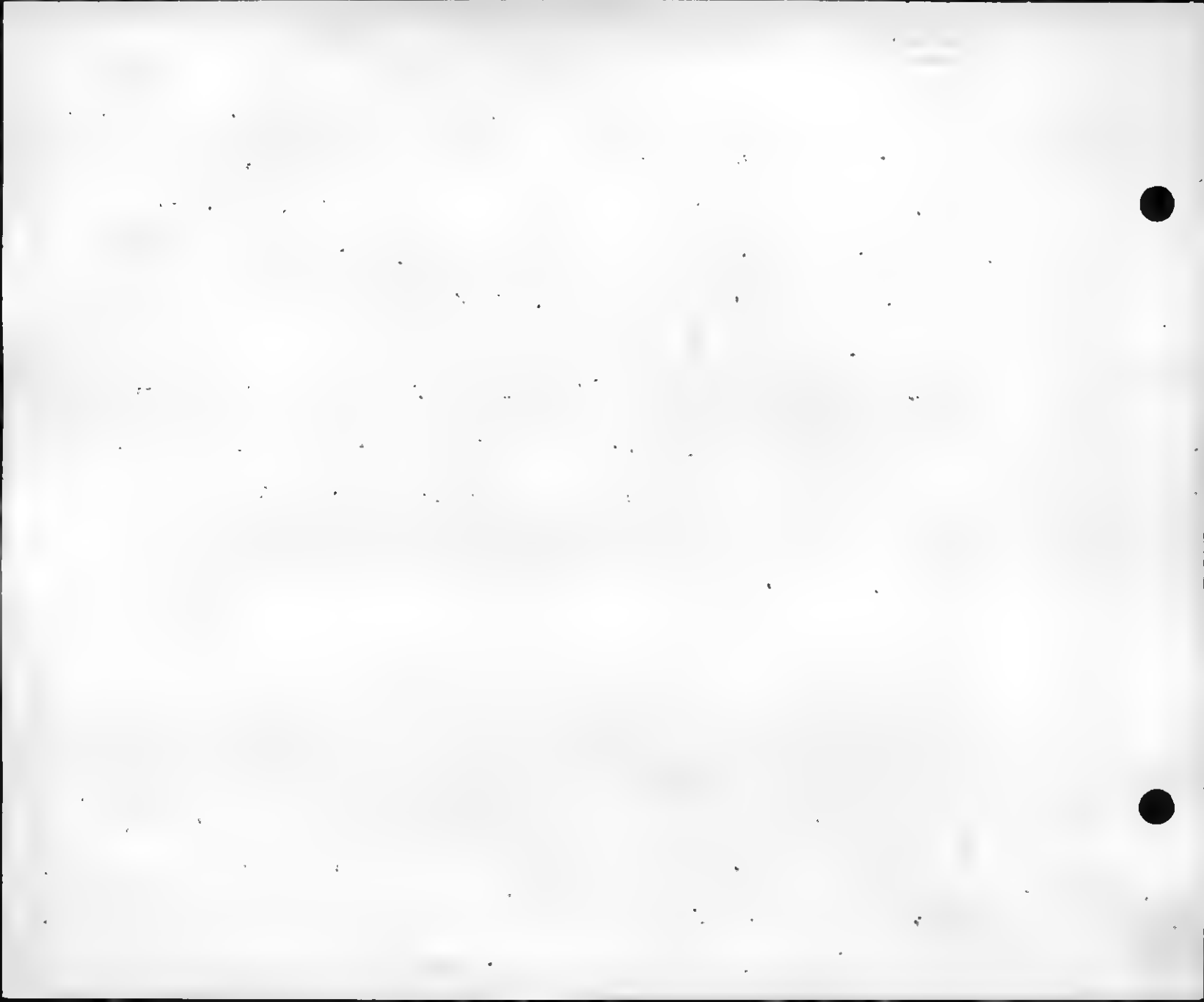
| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|------------------------|--|----------------------------------|---|--|--|---|--|--|--|
| 1 DECEASED-NAME
(Type or print) | | | First <u>Esther</u> Middle <u>NMI</u> Last <u>STEIN</u> | | | 2a. DATE OF DEATH
Month <u>2</u> Day <u>3</u> Year <u>68</u> | | | 2b. HOUR
<u>5:50</u> AM | | |
| 3 SEX
<u>FEMALE</u> | | 4 RACE
<u>WHITE</u> | | 5 DATE OF BIRTH
<u>1-1-93</u> | | | 6 AGE (In years last birthday)
<u>75</u> YRS | | IF UNDER 1 YEAR
MONTHS <u></u> DAYS <u></u> | | IF UNDER 24 HRS
HOURS <u></u> MIN <u></u> |
| 7a BIRTHPLACE (State or foreign country)
<u>PHILADELPHIA PENNA</u> | | | 7b CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<u>BALTO.</u> | | | |
| 10 CITY OR TOWN OF DEATH
<u>Randallstown</u> | | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)
<u>BALTO. CO. GEN. HOSP.</u> | | | 12a USAL OCCUPATION (Kind of work done during most of working life, even if retired)
<u>HOUSEWIFE</u> | | | 12b KIND OF BUSINESS OR INDUSTRY
<u>AT HOME</u> | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admision) STATE <u>PENNA</u> | | | 13b COUNTY
<u>Phila.</u> | | 13c CITY OR TOWN
<u>Phila.</u> | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER
<u>6201 N. 15th ST.</u> | | |
| 14 FATHER'S NAME First <u>Abraham</u> Middle <u>DAVID</u> Last <u>Schwartz</u> | | | 15. MOTHER'S MAIDEN NAME First <u>ANNA</u> Middle <u>Schwartz</u> Last <u>Schwartz</u> | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, na, or (unknown) <u></u> (If yes give war or dates of service) | | | 16b SOCIAL SECURITY NO.
<u>181-38-0799</u> | | |
| 17 INFORMANT
<u>MRS. BETTY NATHAN</u> | | | Address
<u>3402 STEVENSWOOD CT. #21207</u> | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>GASTRO-INTESTINAL BLEEDING</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ULCERATIVE COLITIS</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, nat'lly medical examiner) | | | 21b TIME OF INJURY
HOUR A.M. <u></u> Month <u></u> Day <u></u> Year <u>19</u>
P.M. <u></u> | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21a. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f LOCATION Street or R.F.D. No. <u></u> City or Town <u></u> County <u></u> State <u></u> | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JAN. 20, 1968</u> to <u>FEB. 3, 1968</u> , that (I) (we) last saw the deceased alive on <u>FEB. 3, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE
<u>Fausto Q. Aquino Jr.</u> DEGREE <u></u> ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | | | | | | | | 22c. DATE SIGNED
<u>2-3-68</u> | | |
| 22d. PHYSICIAN'S NAME (Type)
<u>FAUSTO Q. AQUINO JR.</u> | | | | | | | | | 22e ADDRESS
<u>C/O BALTIMORE COUNTY GEN. HOSP.</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b DATE
<u>2-4-68</u> | | 23c NAME OF CEMETERY OR CREMATORY
<u>ROOSEVELT</u> | | | 23d LOCATION (City or Town) (County) (State)
<u>PHILADELPHIA, PENNSYLVANIA</u> | | | |
| 24 FUNERAL DIRECTOR
<u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u> | | | | | | 25a REC'D BY REG STRAR
DATE <u>FEB 6 1968</u> | | 25b. REGISTRAR'S SIGNATURE
<u></u> | | | |



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| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|--|--|---|---|---|---|--|--|--|--|
| 1. DECEASED-NAME (Type or print) WILLIAM DAVID STEVENS | | | | | | 2a. DATE OF DEATH
Month FEB Day 8 Year 1968 | | | 2b. HOUR 3:30 PM | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH 12-22-91 | | | 6. AGE (In years last birthday) 76 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore County Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Mount Wilson | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Mt. Wilson State Hospital | | | 12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired)
FARMER | | | 12b. KIND OF BUSINESS OR INDUSTRY
Construction | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND 13b. COUNTY HARFORD | | | 13c. CITY OR TOWN APRINGTON | | 13d. INSIDE CITY LIM. IS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
Box 396 SINGER RD. | | | | |
| 14. FATHER'S NAME First WILLIAM R. Middle Last STEVENS | | | | 15. MOTHER'S MAIDEN NAME First IDA Middle Last SCHAFER | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown no (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO 212-14 9334 | | 17. INFORMANT Address
Records, Mt. Wilson State Hospital | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
491X IMMEDIATE CAUSE (a) ac Pulmonary, decompensated
DUE TO, OR AS A CONSEQUENCE OF
(b) Pulmonary Emphysema & Fibrosis
DUE TO, OR AS A CONSEQUENCE OF
last 5271 (c) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Pericardial adhesions | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day 19 Year
P.M. | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-12-1968 to 2-8-1968 , that (I) (we) lost saw the deceased alive on 2-8-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE W Newcomer | | | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED Feb. 12, 1968 | | | |
| 22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D. | | | | | | 22e. ADDRESS Mount Wilson, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE Feb. 11, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY St. Carol | | | 23d. LOCATION (City or Town) Baltimore (County) Harford (State) Md. | | | |
| 24. FUNERAL DIRECTOR Harold E. McJones son William, Maryland | | | | | | 25a. REG. BY REGISTRAR Feb 12 1968 | | 25b. REGISTRAR'S SIGNATURE | | | |

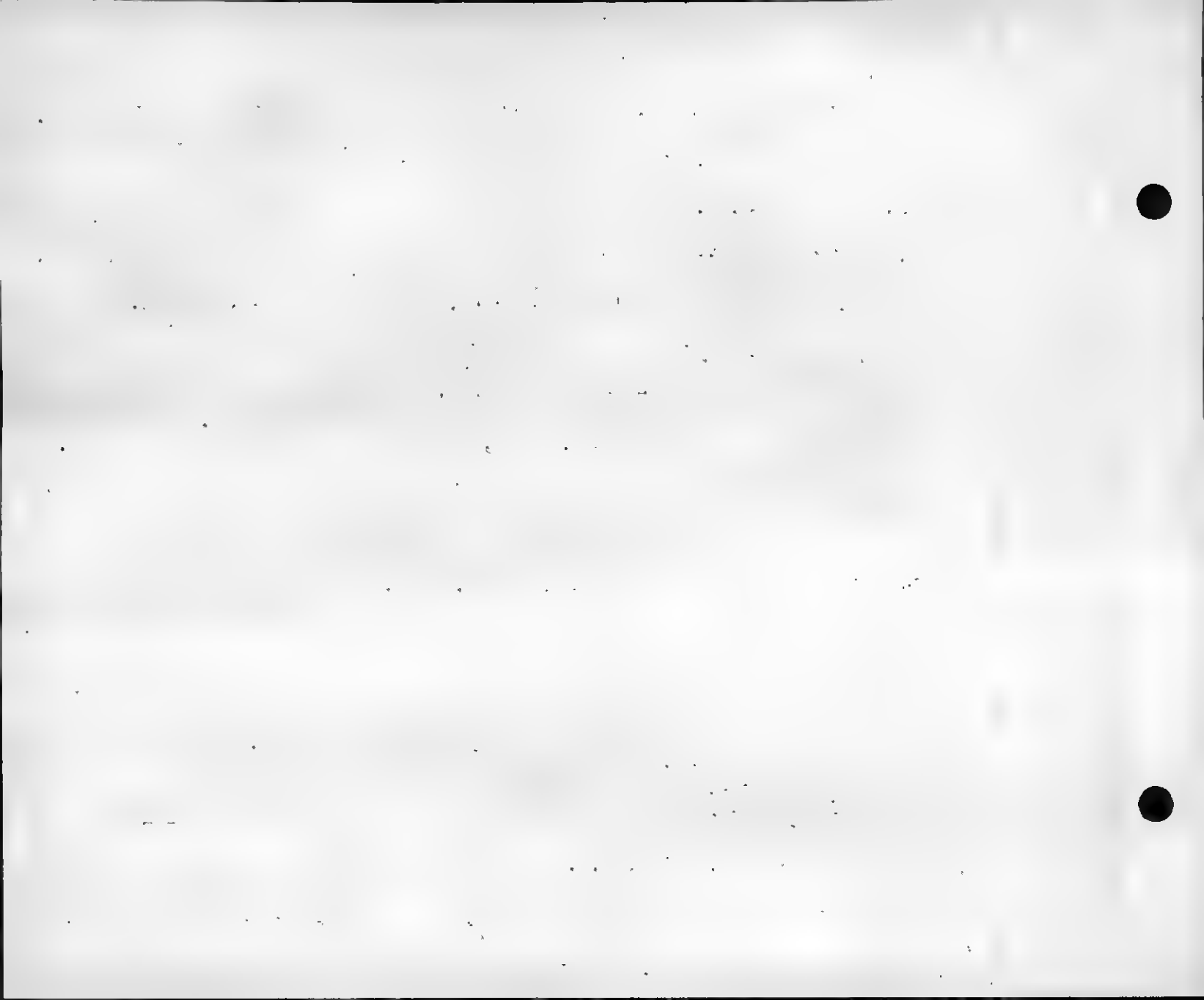


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MIDDLE | | | | | | | | | |
|--|--|---|---|---|--|--|--|---|--|
| <div style="text-align: center;"> <p>2366</p> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</p> <p>CERTIFICATE OF DEATH</p> <p style="text-align: right;">2054</p> </div> | | | | | | | | | |
| 1 DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Philip | | | A. Stewart | | | Month Day Year
February 5 1968 | | 3:00 p.m. | |
| 3. SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (in years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | |
| male | | Negro | | March 12, 1878 | | 89 YRS. | | | |
| 7a BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | |
| Md. | | U. S. | | | | Baltimore | | Md. | |
| 10. CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Catonsville | | | SPRING GROVE STATE HOSP. | | | Laborer | | hwy. dept. | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Res. denoted before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| Md. | | | Prince George's | | | Cedar Hgts. | | 931 - 63rd Ave. | |
| 14 FATHER'S NAME | | | 15 MOTHER'S M.A.D.E.N. NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| William Stewart | | | Cornelia Meredith | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO | | | 17 INFORMANT | | Address | |
| No | | | 579-30-2265 | | | Records: SPRING GROVE STATE HOSPITAL | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, organic | | | | | | | | | |
| X DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (b) | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| Intestinal and cardiac conditions, 1st and 2nd. | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | HOUR A.M. Month Day Year
P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f. LOCATION | | City or Town | | County State | |
| While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | | Street or R.F.D. No | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from Aug. 17, 1967, to Feb. 5, 1968, that (X) (we) last saw the deceased alive on Feb. 5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | | 22c. DATE SIGNED | | | |
| Anthony J. Young, M.D. | | | | | | 2-5-68 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | |
| | | | | | | SPRING GROVE STATE HOSPITAL
Baltimore, Maryland 21228 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) (State) | |
| | | 2-10-68 | | Harmony | | Highland Park | | Md | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| H.S. Washington 45 4925 Dine Court | | | | | | DATE FEB 12 | | | |

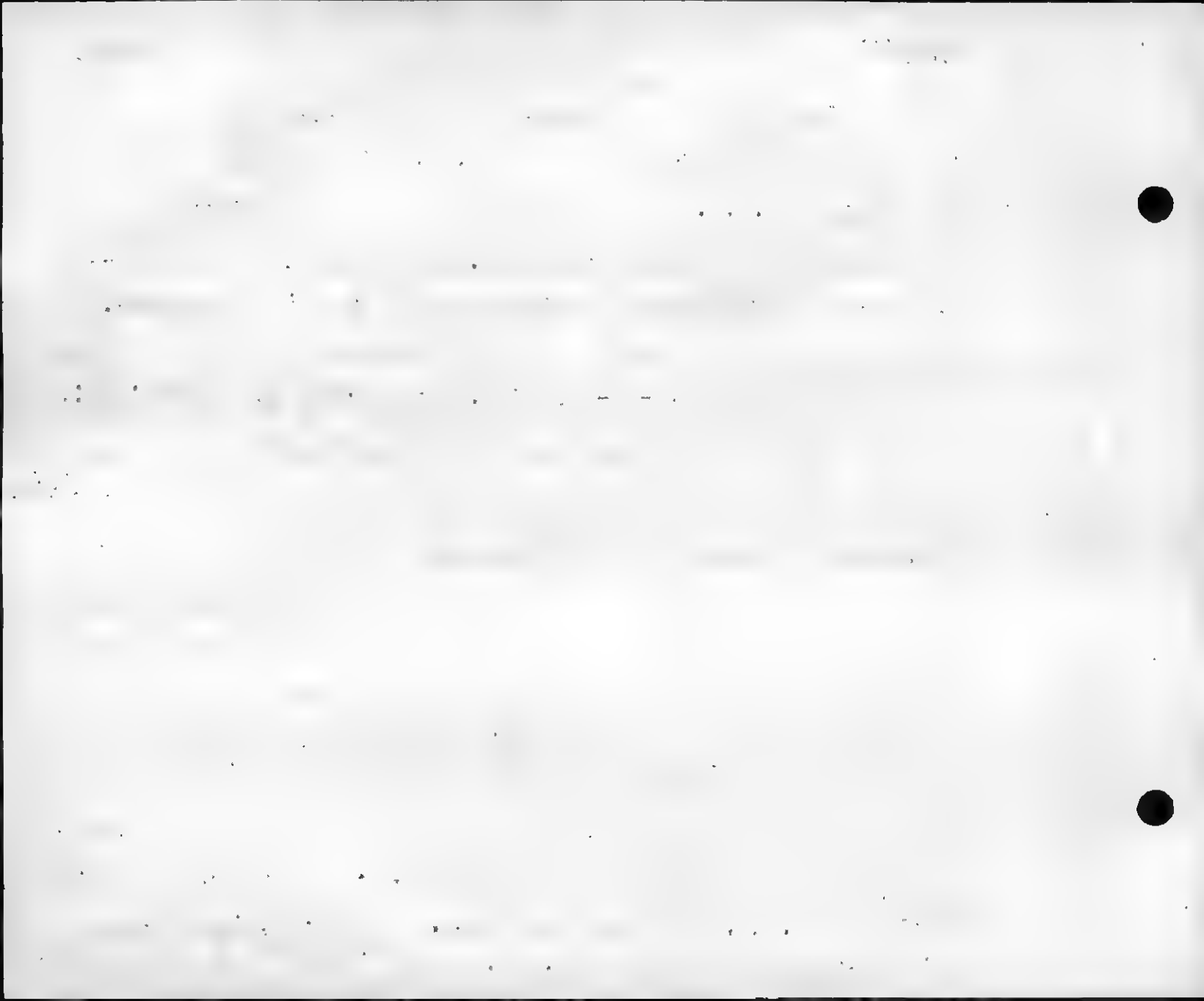
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | |
|---|--|---------|--|------------------|--|--|---------------------------------|--|--|---|-----------------------|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1. DECEASED NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR | | | | |
| Clara Cornell | | | Stout | | | February 19, 1968 | | | 6:30 AM | | | | |
| 3 SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | 7. IF UNDER 24 HRS | | 8. IF UNDER 24 HRS | | |
| Female | | White | | Feb. 12, 1882 | | | 86 YRS. | | MONTHS DAYS HOURS MIN | | MONTHS DAYS HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | |
| New Jersey | | | U.S.A. | | | | | | Baltimore Md | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 2a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Reisterstown | | | Old Hanover Rd. | | | Housewife | | | --- | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER | |
| Maryland | | | Baltimore | | | Reisterstown | | | X | | | Old Hanover Rd. | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | | | |
| Sidell | | | Sarah | | | Hardy | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO | | | 17. INFORMANT | | | Address | | | | |
| No | | | 579-66-2150 | | | Mrs. Vera Kerwin | | | Old Hanover Rd., | | | Reis. Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerosis - generalized</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u> | | | | | | | | | | 2 months | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or RFD No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from September 1967, to February 19 1968, that (I) (we) last saw the deceased alive on February 19 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Clarence E. McWilliam</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED 2-19-68 | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>11904 Reisterstown Rd Reisterstown Md</u> | | | | | | | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | | Feb. 21, 1968 | | | Harleigh Cemetery | | | Camden, New Jersey | | | | |
| 24. FUNERAL DIRECTOR <u>H. J. Ehlhardt</u> ADDRESS <u>Owings Mills, Md.</u> | | | | | | | | | | 25a. RECEIVED BY REGISTRAR <u>FEB 21 1968</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |



Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
FORM REV. 1/68

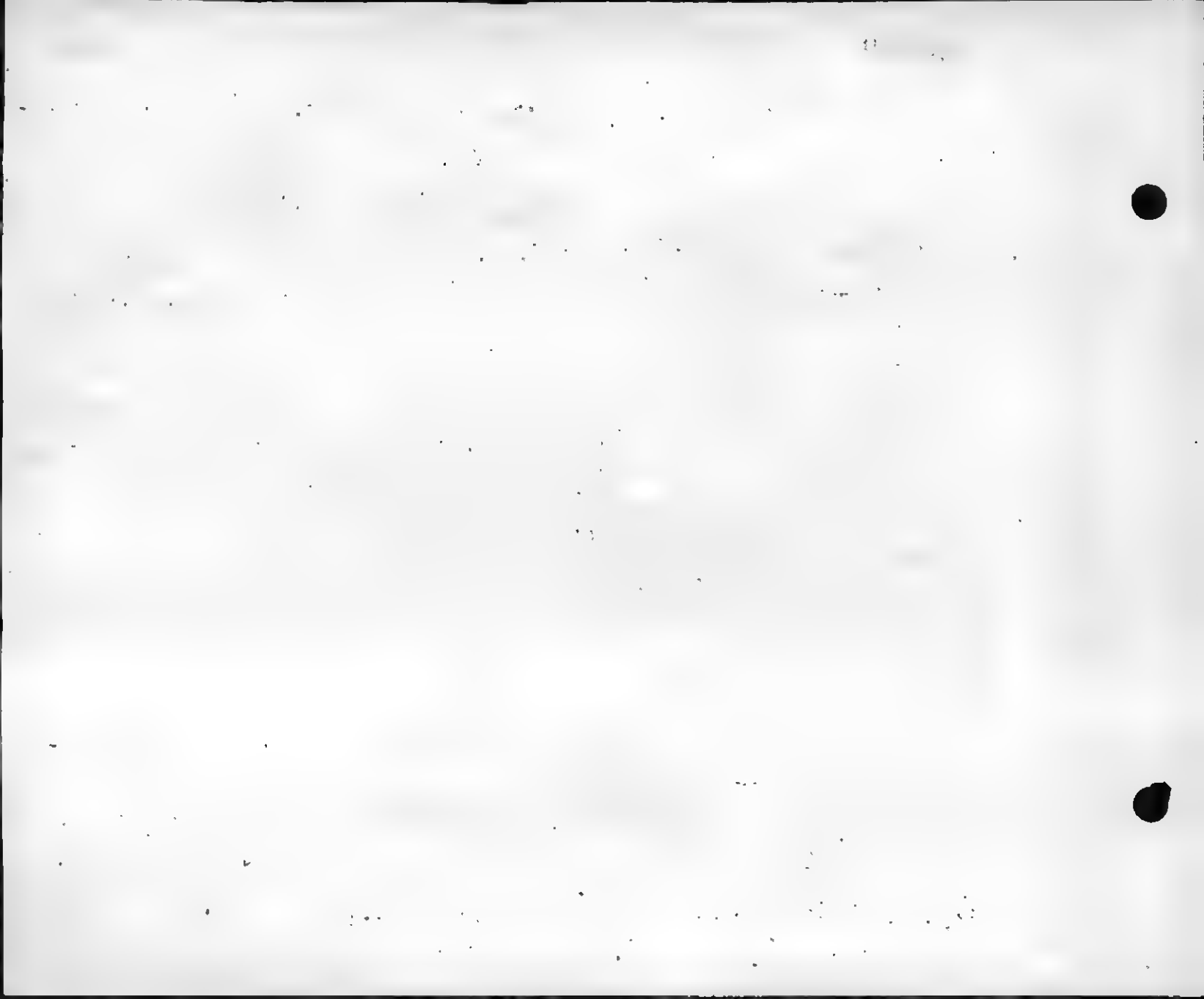
| <div style="display: flex; justify-content: space-between;"> 12368 MARYLAND STATE DEPARTMENT OF HEALTH 02356 </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 CERTIFICATE OF DEATH </div> | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|---|--|---|
| 1. DECEASED NAME
(Type or print) Lillian | | | | First E. Middle Strauss Last | | | | 2a. DATE OF DEATH
Month February Day 8 Year 1968 | | | 2b. HOUR 6:29 MIN AM |
| 3 SEX
Female | | 4 RACE
White | | 5 DATE OF BIRTH
August 10, 1888 | | | 6 AGE (In years last birthday)
79 YRS | | 7 UNDER YEAR
MONTHS 0 DAYS 0 | | 8 UNDER 24 HRS
HOURS 0 MIN 0 |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CIT ZEN OF WHAT COUNTRY?
U. S. A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore | | | | | |
| 10 CITY OR TOWN OF DEATH
Catonsville | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Bloomsbury Retreat Convl. Home | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Dundalk | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
54 Avalon Avenue | | | |
| 14 FATHER'S NAME First William Middle Last Coale | | | | 15. MOTHER'S MAIDEN NAME First Wood Middle Last Md. | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT (Daughter)
Mrs. Anna Marie Fry, 54 Avalon Ave. Dundalk, Md. | | | | Address | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>ARTERIO-SCLEROTIC C-V DISEASE</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>1111 ACUTE INFLUENZAL INFECTION</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/16</u> , 19 <u>66</u> , to <u>2/8</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2/5</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Paul R. Ziegler</i> MD DEGREE | | | | 22c. DATE SIGNED
2/8/68 | | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | |
| 22d. PHYSICIAN'S NAME (Type)
Paul R. Ziegler | | | | 22e. ADDRESS
M. D. 200 Chesnut Hill Dr. Ellicott City, Md. | | | | | | | |
| 23a. BURIAL CREMATION, REMAINS (Specify)
Burial | | 23b. DATE
2/10/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Western Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | | | | |
| 24. FUNERAL DIRECTOR
John J. Duda, 7922 Wise Ave. Dundalk, Md. | | | | | | 25a. REC'D BY REGISTRAR
DATE FEB 13 1968 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--------|--|---|--|--|--|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1 DECEASED NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| George W. Strober | | | | | | Feb. Month 29 Day 1968 | | | 3:55 AM |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | | 6 AGE (In years last birthday) | | F UNDER 1 YEAR
MONTHS DAYS |
| M | | W | | 7/4/1900 | | | 67 YRS. | | H UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| | | | | | | | Baltimore Md | | |
| 10. CITY OR TOWN OF DEATH | | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Baltimore | | | | Caton Ridge N. H. | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE | | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | | | | | | | Owings Mills
Barnes Ave. 21117 | |
| 14 FATHER'S NAME | | | 15 MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO | | 17 INFORMANT Address | | | | |
| | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>(R) upper lobe pneumonia</u>
<u>4129</u> DUE TO, OR AS A CONSEQUENCE OF
Cong. Heart Failure
(b) <u>2 weeks</u>
DUE TO, OR AS A CONSEQUENCE OF
A.S.C.V.D.
(c) <u>month</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<u>malnutrition</u> | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. | | City or Town County State | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>23 Feb</u> , 19 <u>68</u> , to <u>29 Feb</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>23 Feb</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Ralph E. Updike MD</u> | | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
<u>29 Feb 68</u> | | | |
| 22d. PHYSICIAN'S NAME (Type)
<u>Ralph E. Updike</u> | | | 22e. ADDRESS
<u>3, Dogwood Drive 21043</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| <u>Burial</u> | | | <u>Feb 29 1968</u> | | <u>Caton Ridge N. H.</u> | | <u>BALTIMORE Md.</u> | | |
| 24 FUNERAL DIRECTOR | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| <u>Frank H. Newell</u> | | | <u>1800 E. St.</u> | | <u>MAR 1 1968</u> | | <u>Charles Judge</u> | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02358

| | | | |
|--|---|--|--|
| 1 PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Arbutus | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Arbutus | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
903 Maiden Choice Lane | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print)
First Middle Last
VIOLA ELIZABETH SULLIVAN | | 4 DATE OF DEATH
Month Day Year
2 24 1968 | |
| 5 SEX
Female | 6 COLOR OR RACE
Color | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH
1/2/1903 |
| 9. AGE (In years last birthday)
65 yrs | | 10. IF UNDER 1 YEAR
Months Days Hours Min | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 11b. KIND OF BUSINESS OR INDUSTRY | |
| 12. BIRTHPLACE (County & State or foreign country)
Maryland | | 13. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 14. FATHER'S NAME
Henry Knight | | 15. MOTHER'S MAIDEN NAME
Abendschoen | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 17. SOCIAL SECURITY NO
212-03-6554 | |
| 18. INFORMANT
Joseph Sullivan (Husband) | | Address
As Above | |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-Vascular Disease
+1111 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b) DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
 sudden | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (the hospital) attended the deceased from 1/19, 1968 to 2/24, 1968 , that (I) (we) last saw the deceased alive on 2/24, 1968 , and that death occurred at 5:00 PM , from causes and on the date stated above | | | |
| 22a. SIGNATURE
James N. Frederick | | 22b. DATE SIGNED
2/25/68 | |
| 22c. PHYSICIAN'S NAME (Type)
James N. Frederick | | 22d. ADDRESS
1311 Francis Ave. Balto Md 21227 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
2/28/68 | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cem. | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. |
| 24. FUNERAL DIRECTOR
Raymond C. Fink | | ADDRESS
Glen Burnie, Md. | |
| 25a. REC'D BY REGISTRAR
DATE FEB 28 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

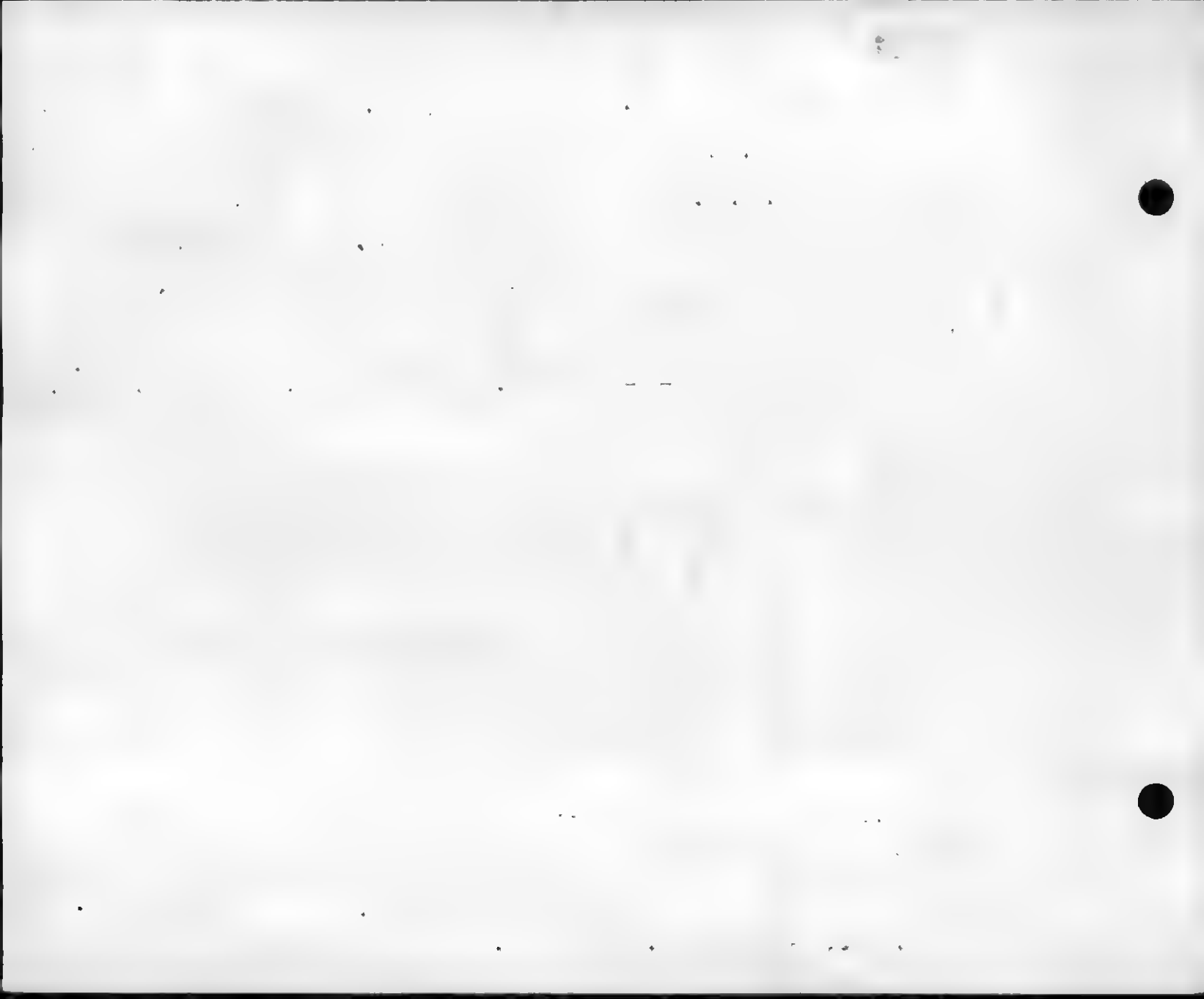


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Every delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--------|---|---|--|--|---|---|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1 DECEASED NAME
(Type or Print) | | | First | | Middle | | Last | | |
| JOSEPH | | | S. | | SWEET Sr. | | | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | | 6 AGE (in years last birthday) | if UNDER 1 YEAR
MONTHS DAYS | | if UNDER 24 HRS
HOURS MIN | | 2a DATE KNOWN OF DEATH ESTIMATED |
| Male | White | Jan. 4, 1926 | | 42 YRS | | | | | Feb. 3, 1968 12:45 |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Maryland | | U. S. A. | | | | Baltimore | | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| Dundalk | | | 2814 Southbrook Rd | | | Electrician - Local #24 | | | |
| 13a U.S.A. RESIDENCE (Where deceased lived if institution residence before admission) STATE | | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER |
| Maryland | | | Baltimore | | Dundalk | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 2814 Southbrook Road |
| 14. FATHER'S NAME | | | First | | Middle | | Last | | |
| Thomas | | | | | Sweet | | Annie Herman | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b SOCIAL SECURITY NO | | 17 INFORMANT (Wife) | | ADDRESS | | |
| Yes | | | WWII | | 219-18-8052 | | Mrs. Marguerite Sweet, 2814 Southbrook Rd. | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lobar Pneumonia | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a DATE OF OPERATION | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b TIME OF INJURY Month, Day Year
HOUR A.M.
P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 8) | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> HOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County | State |
| 22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | Werner U Spitz, M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b DATE SIGNED 2-4-68 | |
| EXAMINER'S NAME (Type) | | | | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | | | ADDRESS (Street, city, town, or county) | | | |
| 23a BURIAL CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) | | (County) | (State) |
| Burial | | 2/7/68 | | Sacred Heart of Jesus Cem. | | Baltimore, Md. | | | |
| 24 FUNERAL DIRECTOR | | | | ADDRESS | | 25a REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | |
| John J. Duda, 7922 Wise Ave. Dundalk, Md. | | | | | | FEB 7 1968 | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

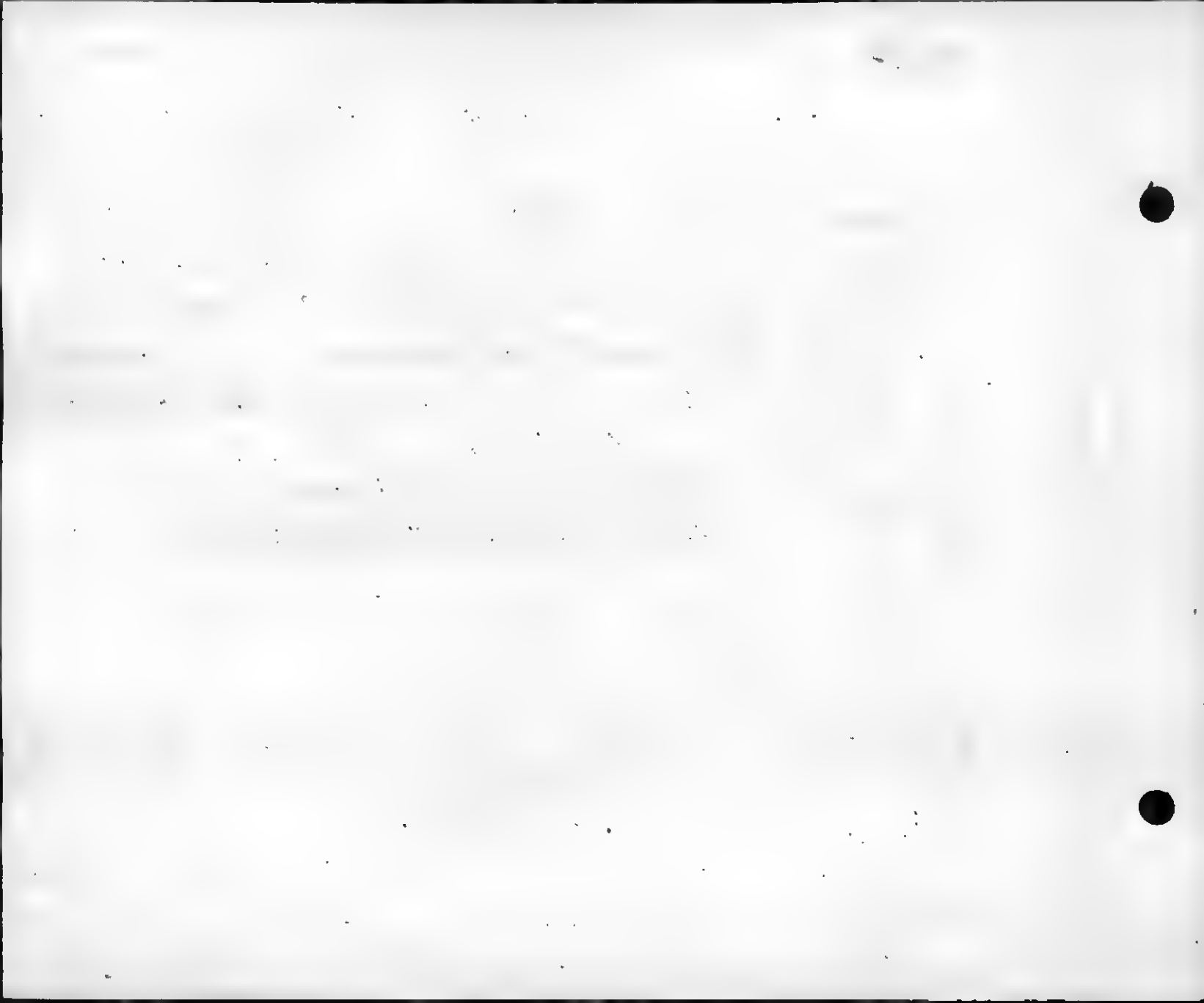
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD 2372

MD 2350

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | |
|---|---|---|--|---|--|---|
| 1. DECEASED NAME
(Type or print) <i>Richard</i> | | First <i>Talbot</i> | Middle | Last | 2a. DATE OF DEATH
Month <i>Feb</i> Day <i>16</i> Year <i>1968</i> | 2b. HOUR
<i>10:20</i> AM |
| 3. SEX
<i>Male</i> | 4. RACE
<i>White</i> | 5. DATE OF BIRTH
<i>10-13-1876</i> | | 6. AGE (In years
last birthday)
<i>91</i> YRS. | IF UNDER 1 YEAR
MONTHS | IF UNDER 24 HRS.
HOURS M.M. |
| 7a. BIRTHPLACE (State or foreign
country) <i>Maryland</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
<i>Baltimore County</i> Md | | | |
| 10. CITY OR TOWN OF DEATH
<i>CATONSVILLE</i> | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
<i>Summit Nursing Home</i> | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
<i>OWNER - LUMBER YARD</i> | 12b. KIND OF BUSINESS OR
INDUSTRY
<i>LUMBER</i> | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE <i>Md.</i> | 13b. COUNTY
<i>Howard</i> | 13c. CITY OR TOWN
<i>Ellicott City</i> | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
<i>127 Church Road</i> | | |
| 14. FATHER'S NAME
First <i>Edward</i> Middle <i>A.</i> Last <i>Talbot</i> | 15. MOTHER'S MAIDEN NAME
First <i>Georgiana</i> Middle <i>Laney</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.
<i>?</i> | 17. INFORMANT
<i>Barbara Fisher</i> | | Address
<i>101 Columbia Rd
Ellicott City, Md.</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) <i>Cardiac Failure</i>
<i>4129</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Chronic Myocardial Disease</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Arteriosclerotic Cardiovascular Disease</i>
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
not | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<i>4 yrs.</i>
<i>5 yrs.</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>+</i> | | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | 21e. PLACE OF INJURY
(AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | 21f. LOCATION
Street or R.F.D. No City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>July</i> , 1960, to <i>2-16</i> , 1968, that (II) (we) last
saw the deceased alive on <i>2-15</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
<i>Thomas F. Herbert, M.D.</i> | DEGREE | ATTENDING
PHYS <input checked="" type="checkbox"/> MED.
DIRECTOR <input type="checkbox"/> STAFF
PHYS <input type="checkbox"/> | 22c. DATE SIGNED
<i>2-16-68</i> | | | |
| 22d. PHYSICIAN'S
NAME (Type) <i>Thomas F. Herbert, M.D.</i> | 22e. ADDRESS
<i>44 Church Rd. Ellicott City, Md 21043</i> | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
<i>BURIAL</i> | 23b. DATE
<i>2-19-68</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>St Johns</i> | 23d. LOCATION (City or Town) (County) (State)
<i>Ellicott City Howard Md.</i> | | | |
| 24. FUNERAL DIRECTOR
<i>Higginbotham-Slack</i> | ADDRESS
<i>Ellicott City, Md.</i> | 25a. REC'D BY REGISTRAR
DATE <i>FEB 21 1968</i> | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |



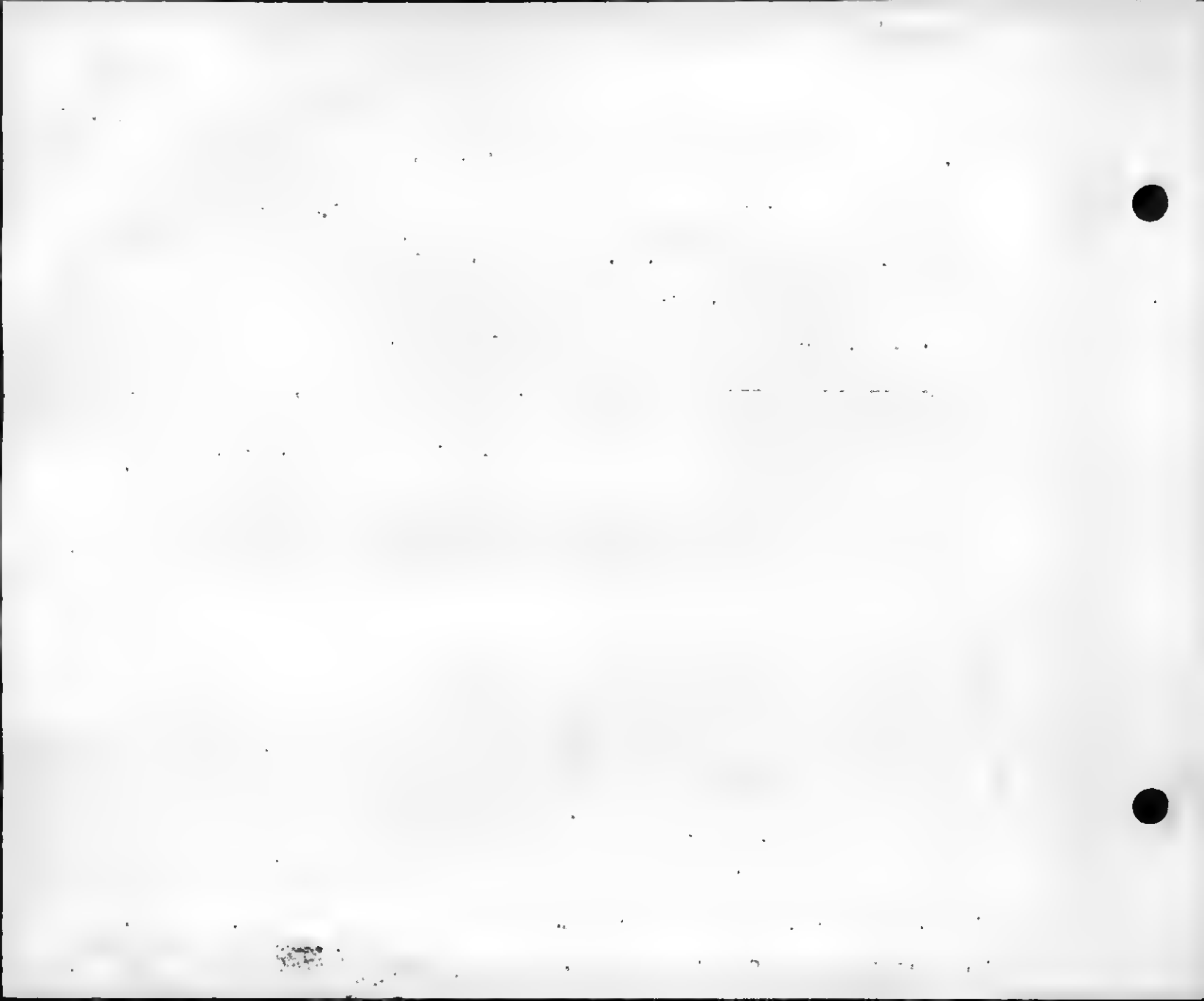
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VR A15 (4)
30A REV 1/68

MD 378
MAY 1968
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | | |
|--|--------|--|------------------|---|--------------------------------|---|-------------------|----------------------------|--|
| 1 DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a DATE OF DEATH | | | 2b HOUR | |
| Anna | | Brown | | Taylor | Month | Day | Year | 68 9:22 a M | |
| 3 SEX | 4 RACE | | 5. DATE OF BIRTH | | 6 AGE (In years last birthday) | | 7 IF UNDER 1 YEAR | | 8 IF UNDER 24 HRS. |
| Female | Cau | | Jan. 19, 1886 | | 82 | | MONTHS DAYS | | HOURS MIN |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | |
| Maryland | | U.S.A. | | | | Baltimore Md. | | | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | Greater Baltimore Medical Center | | Housewife | | Home | | | |
| 13a USUA. RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | 13e STREET AND NUMBER | |
| Maryland | | Baltimore | | Monkton | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | Corbett and Matthews Roads | |
| 14 FATHER'S NAME | | 15 MOTHER'S MAIDEN NAME | | | | | | | |
| Charles M. Brown | | Julia Coleman | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service) | | 16b SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| | | | | A. Frederick Taylor, Monkton, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> | | | | | | | | | |
| 4129 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 4221 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | Yes | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) | | | | | |
| | | HOUR A.M. Month Day Year
P.M. 19 | | | | | | | |
| 21d INJURY OCCURRED | | 21a. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/20, 19 68, to 2/20/19 68, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | 22c DATE SIGNED | |
| R. Breiteneker, M.D. | | | | | | | | 2/20/68 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | 22e ADDRESS | |
| R. Breiteneker, M.D. | | | | | | | | 6701 N. Charles Street | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | | | |
| BURIAL | | Feb. 22, 1968 | | Darlington | | Darlington, Maryland | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REG. STR. | | 25b. REGISTRAR'S SIGNATURE | | | |
| Wm. Cook-Brooks Towson, 1050 York Rd. Towson Maryland | | | | FEB 23 1968 | | [Signature] | | | |

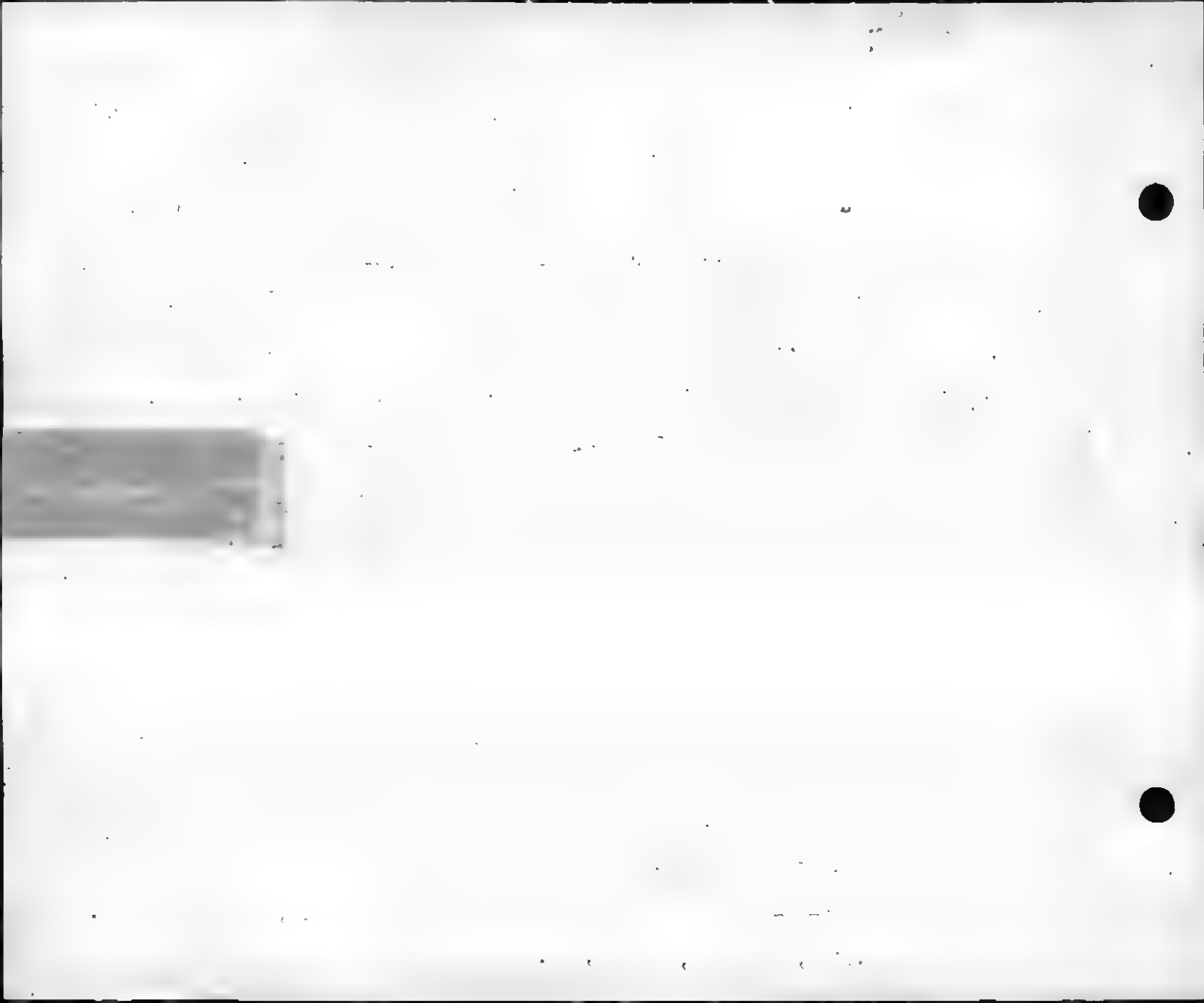


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | |
|--|--|---------|--|------------------|--|---|---------------------------------|--|--|--|-----------------|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | | |
| JAMES | | | TAYLOR | | | February 18, 1968 | | | 4:30 PM | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (in years last birthday) | | 7. UNDER 1 YEAR | | 8. UNDER 24 HRS | | |
| male | | Negro | | 10/6/1895 | | | 72 YRS. | | MONTHS DAYS | | HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | |
| Virginia | | | U. S. A. | | | | | | Baltimore County, | | | Md | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Mount Wilson | | | Mt. Wilson State Hosp. | | | Sanmill water | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET AND NUMBER | |
| MD | | | Caroline | | | Denton | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 5th Street | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | |
| Unknown | | | Ophelia TAYLOR | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | | | |
| Unknown | | | 19-07-7568 | | | Records, Mt. Wilson State Hospital | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Tuberculosis Meningitis | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (b) Pulmonary Tuberculosis | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION | | | Street or R.F.D. No. City or Town County State | | | | |
| | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/14/1968, to 2/18/1968, that (I) (we) last saw the deceased alive on 2/18/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | | | | | | | | |
| William Newcomer | | | 2/18/68 | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | | | | | |
| William Newcomer, M.D. | | | Mount Wilson, Md. | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| | | | 2-21-1968 | | | SPRING GROVE CEMETERY | | | Denton, Caroline Md. | | | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Charles W. Hill, Mortician, | | | Denton, Md. | | | DATE Feb 21 1968 | | | Charles J. [Signature] | | | | |

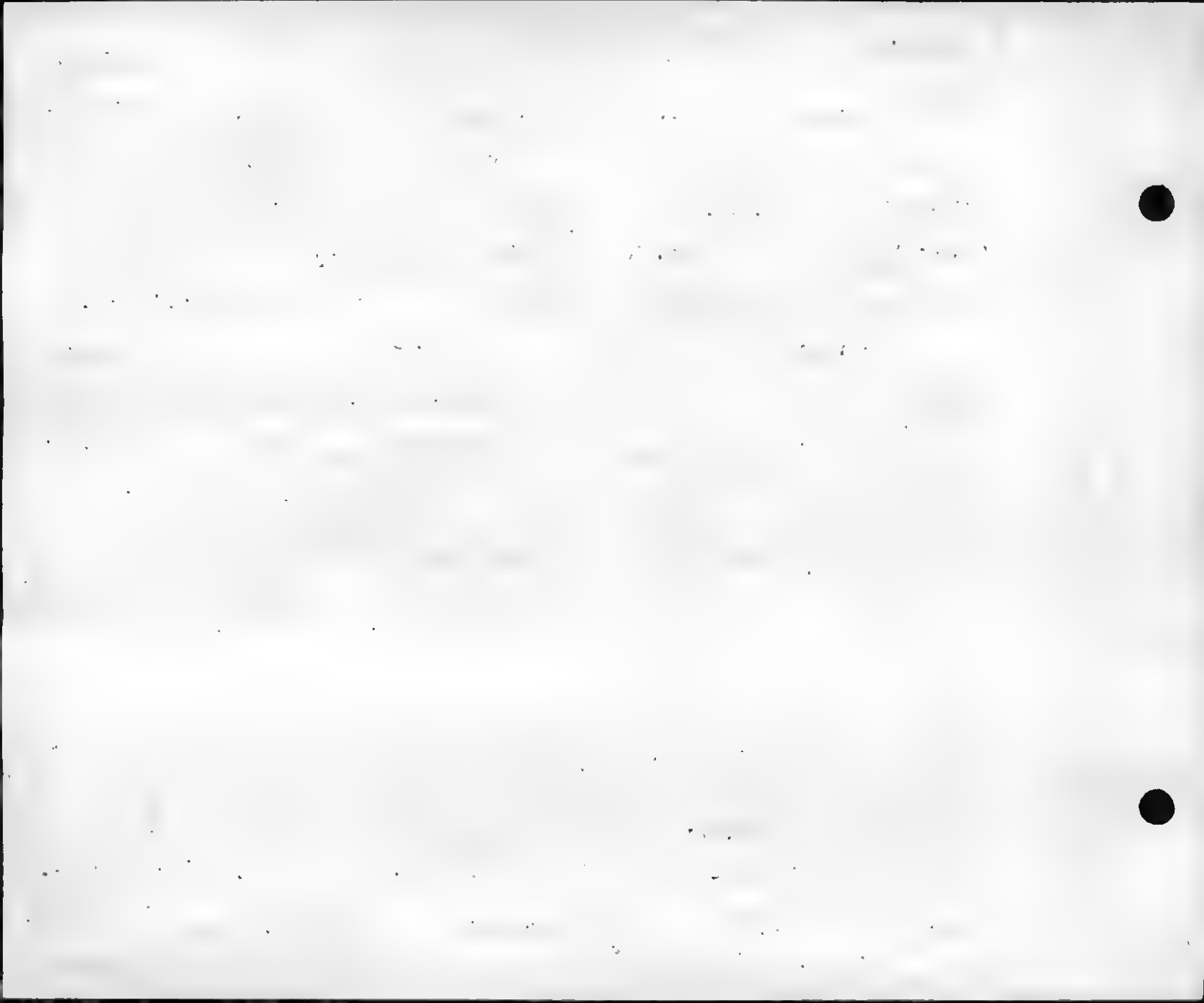


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | |
|--|---|---|---|--|--|
| 1 DECEASED-NAME (Type or print) First Middle Last
Anna L. Thomas | | | 2a. DATE OF DEATH Month Day Year
Feb. 12 1968 | | 2b HOUR
12:10 |
| 3 SEX
Female | 4 RACE
White | 5. DATE OF BIRTH
July 4 1882 | | 6 AGE (In years last birthday)
85 YRS | 7 UNDER YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN |
| 7a BIRTHPLACE (State or foreign country)
Missouri | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 COUNTY OF DEATH
Baltimore Md. | | |
| 10 CITY OR TOWN OF DEATH
Catonsville | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
House in the Pines | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Housewife | 12b KIND OF BUSINESS OR INDUSTRY
none | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | 13b COUNTY
Baltimore | 13c CITY OR TOWN
Rural Balto | 13d INSIDE CITY, JAN 15?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e STREET AND NUMBER
7320 Windsor Mill Rd. | |
| 14 FATHER'S NAME First Middle Last
Unknown | | 15. MOTHER'S MAIDEN NAME First Middle Last
Maria Eichhorn | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) (If yes give war or dates of service)
no | | 16b. SOCIAL SECURITY NO
213-34-2899 | 17. INFORMANT Address
Marguerite Leutner 7320 Windsor Mill Rd 7 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u>
428X
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized arteriosclerosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12 hr
15 yr. | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
422. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY)
OFFICE BUILDING ETC. | | 21f LOCATION Street or R.F.D. No City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-24, 1964, to 2-12, 1968, that (I) (we) last saw the deceased alive on 2-12-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE
Robert B. Galligan, M.D.
DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | | 22c. DATE SIGNED
2-12-68 | |
| 22d PHYSICIAN'S NAME (Type)
R. B. Galligan, M.D. | | | | 22e. ADDRESS
6304 Frederick Ave, Bldg 23, Ft. Det. 21228 | |
| 23a BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE
2/15/68 | 23c NAME OF CEMETERY OR CREMATORY
Lorraine Cemetery | | 23d LOCATION (City or Town) (County) (State)
Woodlawn Balto co Md. | |
| 24. FUNERAL DIRECTOR
Loring Byers | | 25a. REC'D BY REGISTRAR
DATE FEB 16 1968 | | 25b REGISTRAR'S SIGNATURE
Charles Young | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

| MAY 1968 | | | | | | | | | | |
|---|---------|------------------------------|--|--|--|---|--|-----------------------------------|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | | |
| Rita Florence Thompson | | | | | | Month Day Year | | 1968 6:00 AM | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (in years) | 7. UNDER YEAR | 8. UNDER 24 HRS | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | | |
| Female | White | 2/14/19 | 48 YRS | MONTHS | DAYS | Month Day Year | | 1968 4:54 AM | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Pennsylvania | | USA | | | | Baltimore Md | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Abbutus | | | 1711 Park Avenue | | | Housewife | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | | Baltimore | | Arbutus | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 1711 Park Avenue 21227 | |
| 4. FATHER'S NAME | | | 5. MOTHER'S MAIDEN NAME | | | | | | | |
| Bruce Clarke | | | Elizabeth Flood | | | | | | | |
| 6a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT ADDRESS | | | | | |
| | | | 161-0907263 | | Mr. Aubrey G. Thompson 1711 Park Avenue | | | | | |
| 8. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Asphyxia by Hanging - Self Inflicted</u> | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | |
| | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| CAUSE OF DEATH | | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | |
| AT WORK <input type="checkbox"/> | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER | | | 22b. DATE SIGNED | | | | |
| James N. Frederick | | | | | | 2/2/68 | | | | |
| EXAMINER'S NAME (Type) | | | ASS STANT MEDICAL EXAMINER | | | | | | | |
| James N. Frederick, M.D. | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | |
| | | | ADDRESS (Street, city, town, or county) | | | 1311 Francis Avenue | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 2-5-1968 | | Holy Cross Cemetery | | Havertown, Pennsylvania | | | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Howard H. Hubbard, 4107 Wilkens Ave. | | | 21229 | | | FEB 5 1968 | | | | |

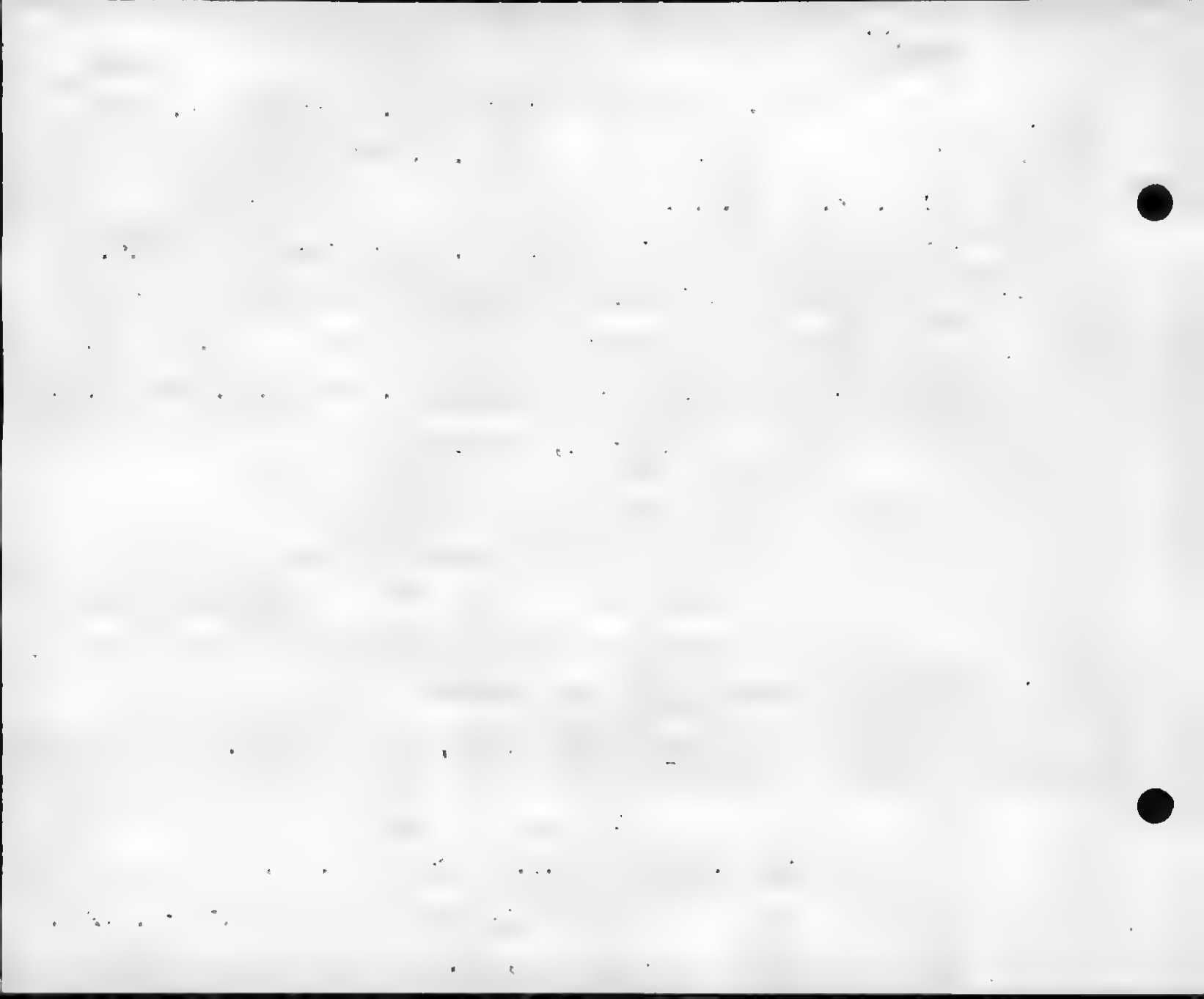


TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

22565

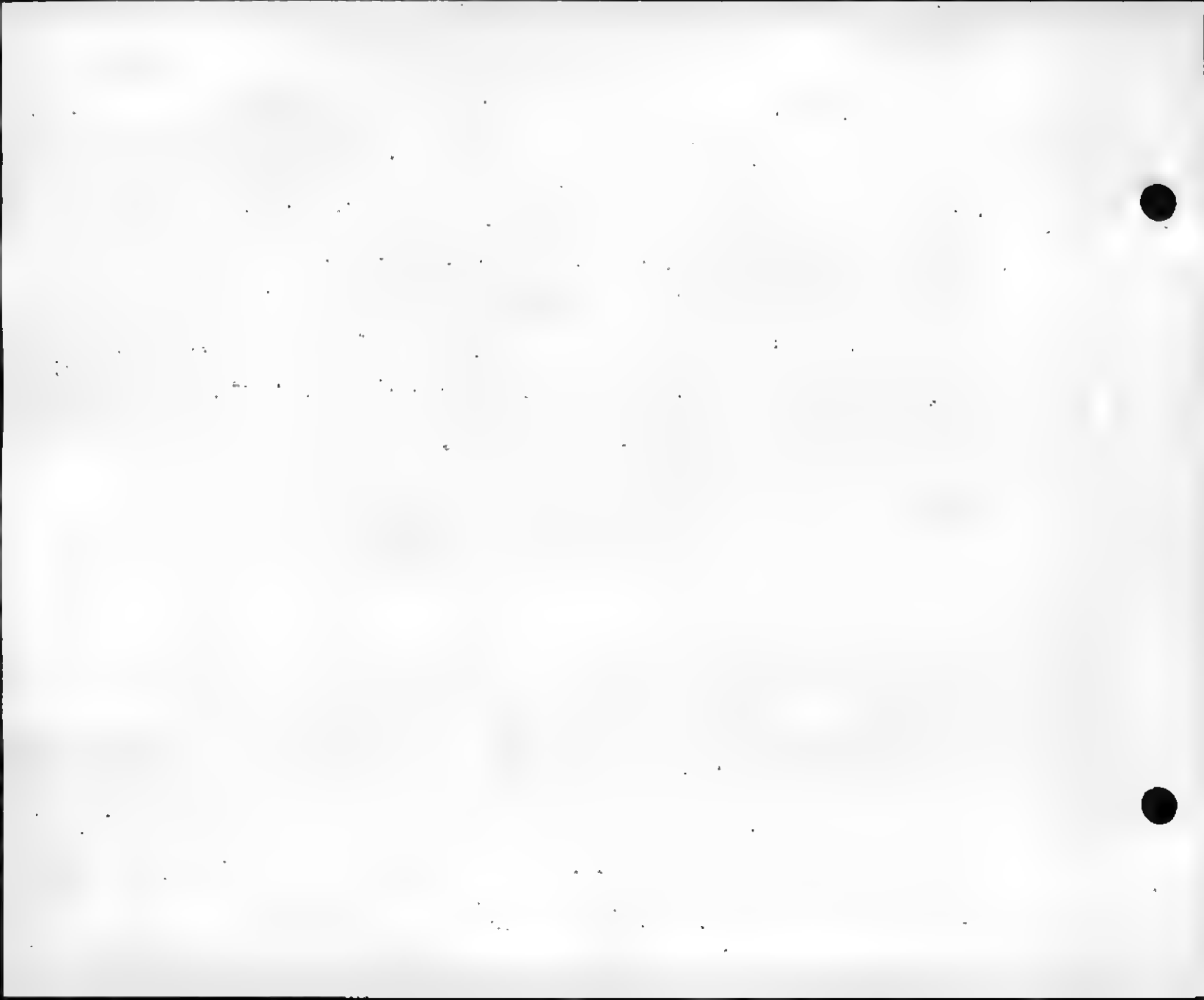
| | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|-------------------------------|--|
| 1. DECEASED-NAME
(Type or print) | | First
RICHARD | | Middle
HAROLD | | Last
TRAINOR Sr. | | 2a. DATE OF DEATH
Month Day Year
February 4, 1968 | | 2b. HOUR
10P.M. | |
| 3 SEX
Male | | 4 RACE
White | | 5 DATE OF BIRTH
Oct. 9, 1900 | | 6 AGE (In years last birthday)
67 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Balto., Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore | | | | | |
| 10 CITY OR TOWN OF DEATH
Pikesville | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
320 Upland Rd. | | 12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired)
Postman | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Mail | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before adm ssion) STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Pikesville | | 13d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 13e. STREET AND NUMBER
320 Upland Road | | | |
| 14. FATHER'S NAME First Middle Last
Patrick Trainor | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Mary G. Lynch | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) Yes WWI 1917-18 | | 16b. SOCIAL SECURITY NO.
215-03-5665 | | 17 INFORMANT Address
Richard H. Trainor, Jr. Upperco, Md | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma, stomach
1/1/7
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH.
1 year | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4 Feb., 1968 , to 4 Feb., 1968 , that (I) (we) lost
saw the deceased alive on 4 Feb., 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Charles H. Williams M.D. DEGREE M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (Type)
Charles H. Williams M.D. | | 22e. ADDRESS
Pikesville, Md. 21208 | | | | | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
2/7/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Woodlawn, Balto. Co. Md. | | | | | |
| 24. FUNERAL DIRECTOR
A. J. Schmitt ADDRESS
Owings Mills, Md. | | | | 25a. RECD BY REGISTRAR
FEB 7 1968 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | |



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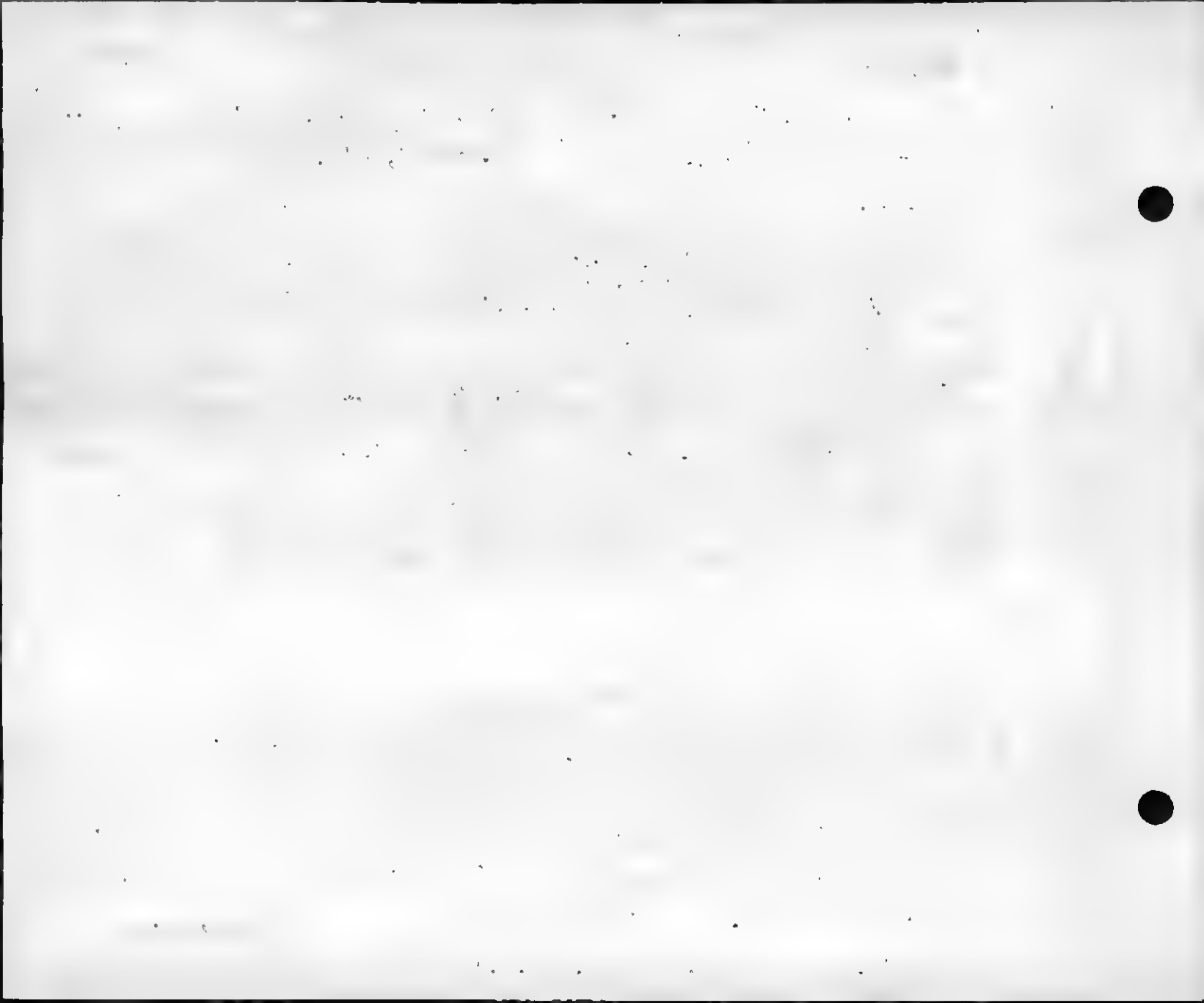
| <div>Item 28 Film 398 2-29-68</div> <div>2373</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>2361</div> | | | | | | | | | | | |
|---|--|--|--|--|--|---|---|--|--|--|--|
| 1 DECEASED NAME
(Type or print) Dorothy A. TUTTLE | | | 2a DATE OF DEATH
Month February Day 19 Year 1968 | | | 12b HOUR
11:40 P. M. | | | | | |
| 3 SEX
Female | | 4 RACE
White | | 5 DATE OF BIRTH
June 27, 1914 | | 6 AGE (In years lost birthday)
53 YRS | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | IF UNDER 24 HRS
HOURS 0 MIN 0 | |
| 7a BIRTHPLACE (State or foreign country)
Maryland | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH
Baltimore, Md | | | | | |
| 10 CITY OR TOWN OF DEATH
Towson | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)
ST. JOSEPH HOSPITAL | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Homemaker | | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE
Maryland | | | 13b COUNTY
Baltimore | | 13c CITY OR TOWN
Baltimore | | 3a INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER
8910 Lennings Lane | | |
| 14 FATHER'S NAME First Middle Last
Leo F. Gill | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Elizabeth Hatten Field | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown (If yes give war or dates of service)
No. | | | 16b. SOCIAL SECURITY NO.
214-03-4308 | | 17. INFORMANT
Clyde S. Hill 1711 Northview Road. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized carcinomatosis
114X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Carcinoma-left breast
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION
1/10 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 1/30/ 19 68 to 2/19/ 19 68 , that (I) (we) lost saw the deceased alive on 2/19/ 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
William A. Rogers, M.D. | | | | | | DEGREE
M.D. | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED
February 19, 1968 | |
| 22d. PHYSICIAN'S NAME (Type)
William A. Rogers, M.D. | | | | 22e. ADDRESS
815 Eastern Ave., Baltimore, Md. 21221 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
Feb. 22, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith Cemetery | | 23d. LOCATION (City or Town)
Balto. | | County
Md. | | State | |
| 24. FUNERAL DIRECTOR
Philip E. Crach | | | | ADDRESS
1211 Chesaco Ave | | 25a. REC'D BY REGISTRAR
DAF-B 23 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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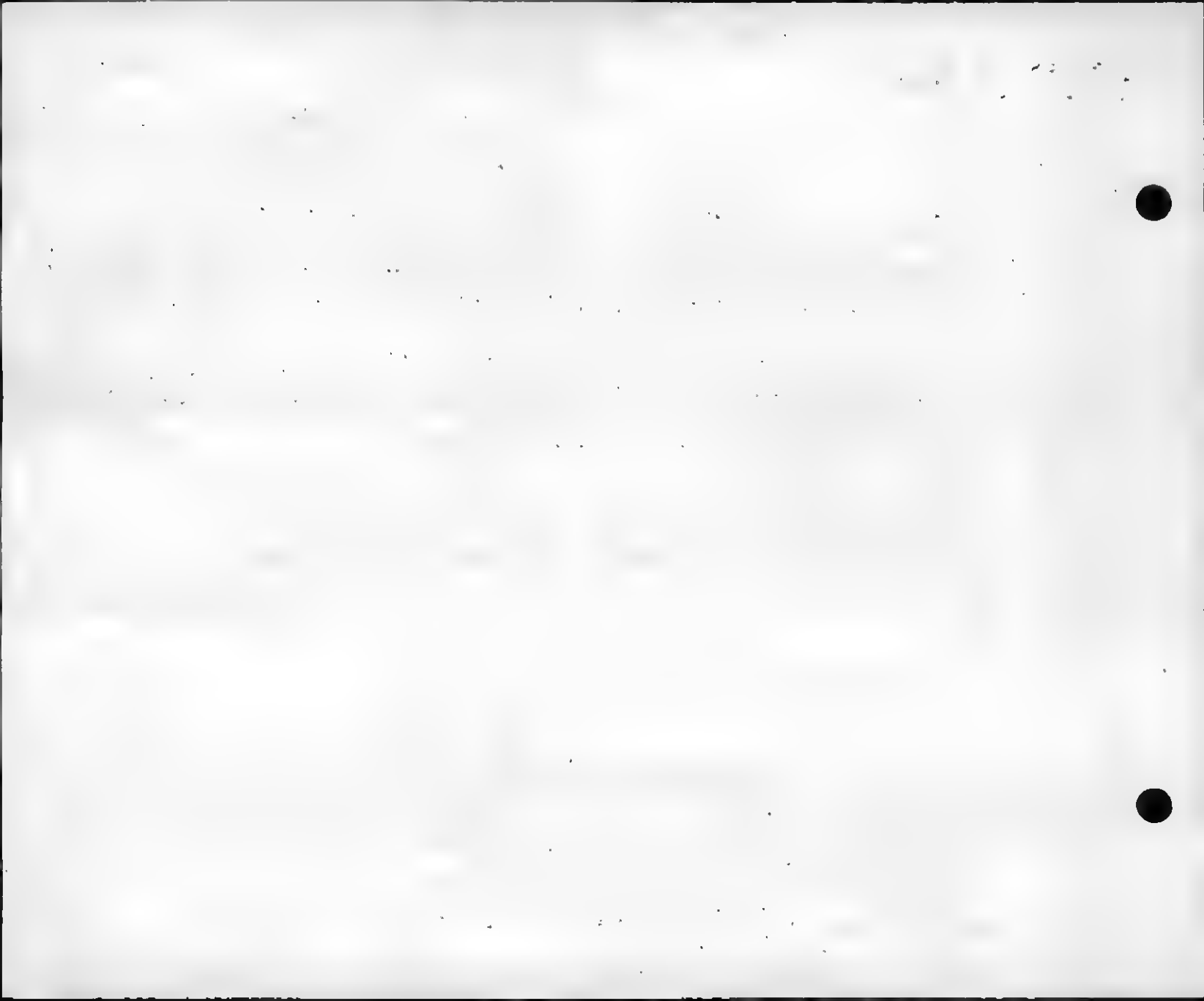
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | First | | Middle (Bates) | | Last | | 2a. DATE OF DEATH | | 2b. HOUR | |
| HELENA | | A. | | U | | M B A C H | | Feb. 6, 1968 | | 2:45am | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| female | | white | | November 5, 1880. | | 87 YRS | | MONTHS DAYS | | HOURS MIN | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Penna. | | USA | | | | Baltimore | | Md. | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Towson | | Chesapeake Manor | | Housewife | | | | | | | |
| 13a USUA. RES DENCE (Where deceased lived, if institution. Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | |
| Md. | | Balto. | | Balto. #4 | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 1641 Myones | | | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | First Middle Last | |
| John | | Bates | | | | | | ? Oyler | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT | | Address | | | | | |
| No | | None | | Mrs. Ida Hollander | | (Same) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Coronary arteriosclerosis</u> | | | | | | | | | | 5 yrs. | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) <u>Cardiovascular disease</u> | | | | | | | | | | 20 yrs. | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | | |
| <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | HOUR A.M. Month Day Year | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. | | 21f. LOCATION | | Street or R.F.D. No | | City or Town | | County State | |
| While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1949, to Feb. 6, 1968, that (I) (we) last saw the deceased alive on Feb. 5, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | |
| Dr. M. Bacon, M.D. | | | | | | | | | | 2/6/68. | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | |
| Dr. A. M. Bacon | | | | | | 2810 Taylor Avenue, Balto.-34 | | | | | |
| 23a. BURIAL, CREMATION, REMEM. | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | |
| Burial | | 2/9/68. | | Parkwood Cemetery | | Baltimore, Md. | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Leonard J. Ruck, Inc.-Balto., Md...14 | | | | | | | | FEB - 8 1968 | | JFC | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1 DECEASED NAME (Type or print) Joseph | | | First Middle Last Vain | | | 2a DATE OF DEATH Month 2 Day 12 Year 68 | | | 2b HOUR 8:15 P | | |
| 3. SEX Male | | | 4 RACE White | | | 5 DATE OF BIRTH 12-23-1891 | | | 6 AGE (In years last birthday) 76 YRS | | |
| 7a BIRTH-PLACE (State or foreign country) Austria | | | 7b. CITIZEN OF WHAT COUNTRY? U.S. A | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 COUNTY OF DEATH Baltimore | | |
| 10 CITY OR TOWN OF DEATH Garrison | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Felixliegh Nursing Home | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Datedodd's Tailor | | | 12b. KIND OF BUSINESS OR INDUSTRY men's clothing | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md | | | 13b COUNTY Baltimore | | | 13c CITY OR TOWN Pikesville | | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME First Middle Last Francis Zyta | | | 15. MOTHER'S MAIDEN NAME First Middle Last Catherine Zyputa | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO | | | 16b SOCIAL SECURITY NO 215-03-7095 | | |
| 17 INFORMANT Margaret V. Williams | | | Address 1632 Reisterstown Rd. Pikesville, Md. | | | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, lung | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 months | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | | 21f LOCATION Street or RFD No City or Town County State | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 7 Oct , 19 62 , to 12 Feb , 19 68 , that (I) (we) last saw the deceased alive on 10 Feb , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | | | | |
| 22b SIGNATURE Charles H. Williams M.D. | | | DEGREE M.D. | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED 12 Feb 68 | | |
| 22d. PHYSICIAN'S NAME (Type) Charles H. Williams M.D. | | | 22e ADDRESS Pikesville 8, Md. | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b DATE 15 Feb-1968 | | | 23c NAME OF CEMETERY OR CREMATORY Glenn Haven Memorial Pk | | | 23d LOCATION (City or Town) (County) (State) Clon Buerie Md. | | |
| 24 FUNERAL DIRECTOR R. V. Singleton | | | ADDRESS Singleton Funeral Home / Clon Buerie | | | 25a REC'D BY REGISTRAR DATE FEB 1 | | | 25b. REGISTRAR'S SIGNATURE | | |



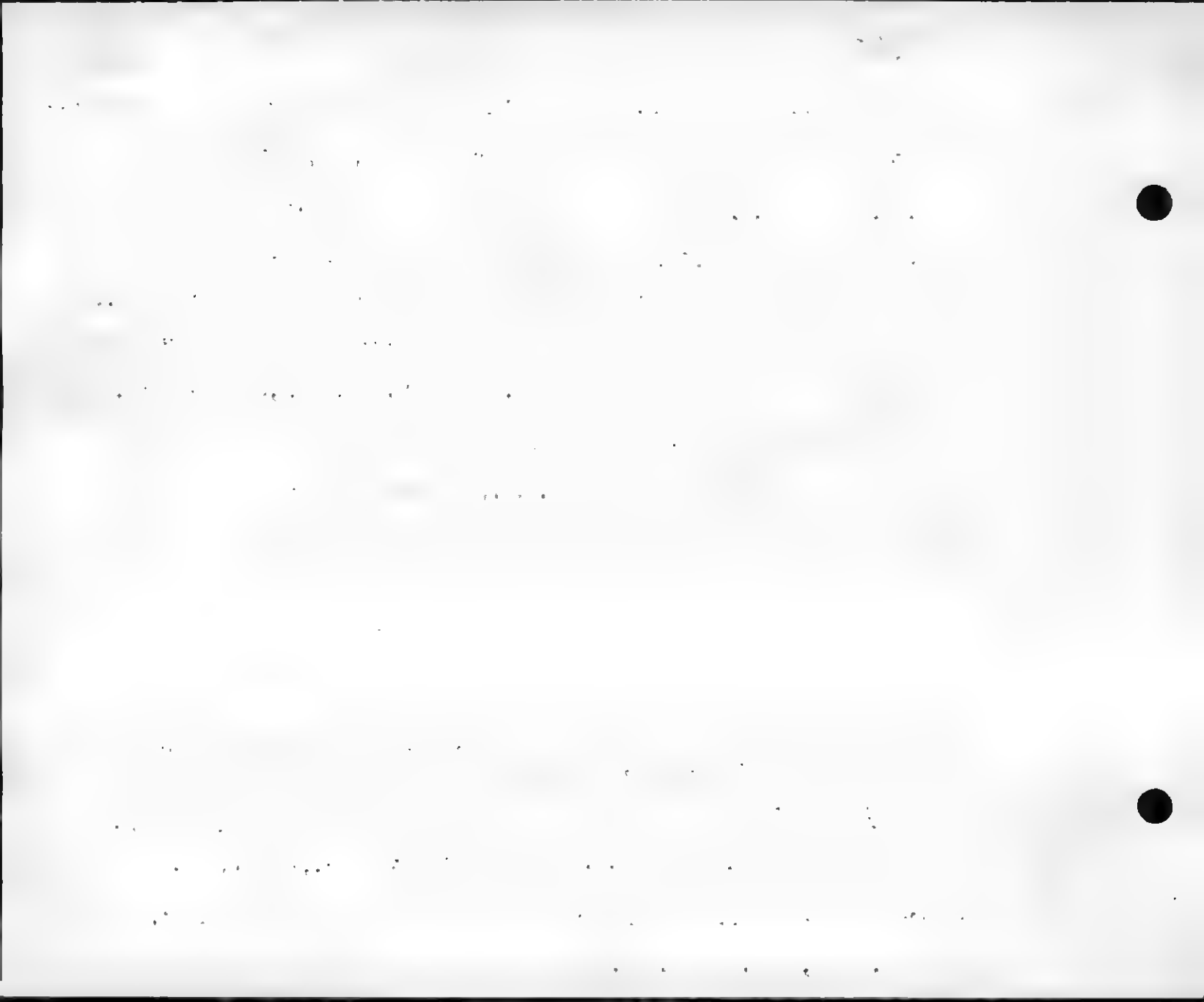
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15(4) U
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | | |
|---|--|---|---------------------|--|---|---|--------------------------|--|---|
| 1 DECEASED NAME
(Type or print) | | First
CATHERINE | Middle
M. | Last
VAN SANT | 2a DATE OF DEATH
Month February Day 9 Year 1968 | | 2b HOUR
7:35pm | | |
| 3. SEX
Female | | 4 RACE
White | | 5. DATE OF BIRTH
December 10, 1887 | | 6. AGE (In years last birthday)
80 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN |
| 7a BIRTHPLACE (State or foreign country)
W. Va. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> D. VORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH
Baltimore Md | | | |
| 10 CITY OR TOWN OF DEATH
Towson | | 11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)
St. Joseph Hospital | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 3a USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIM TSP
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER
8303 Avondale Rd., 21234 | |
| 14 FATHER'S NAME
First John Middle Last Corrigan | | 15. MOTHER'S MAIDEN NAME
First Mary Middle Last Philbin | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, pp. or unknown) (If yes give war or dates of service)
No | | 16b. SOCIAL SECURITY NO | | 17 INFORMANT
Address
Mr. Irving H. Van Sant, 861 Park Ave. 21201 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1 DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Respiratory Arrest
435.4
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) C.V.A., Cerebral Thrombosis
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)
332x | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from January 30 1968 , to February 9, 1968 , that (I) (we) last saw the deceased alive on February 9, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Alexis S. Sayoc M.D. | | DEGREE | | ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/9/68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Alexis S. Sayoc, M.D. | | 22e. ADDRESS
7620 York Rd., Towson, Md. | | | | | | | |
| 23a BURIAL, CREMATION, REMOVA (Specify)
Burial | | 23b. DATE
2/12/68. | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | | | |
| 24 FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Balto. Md. 21214 | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE 13 1968 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

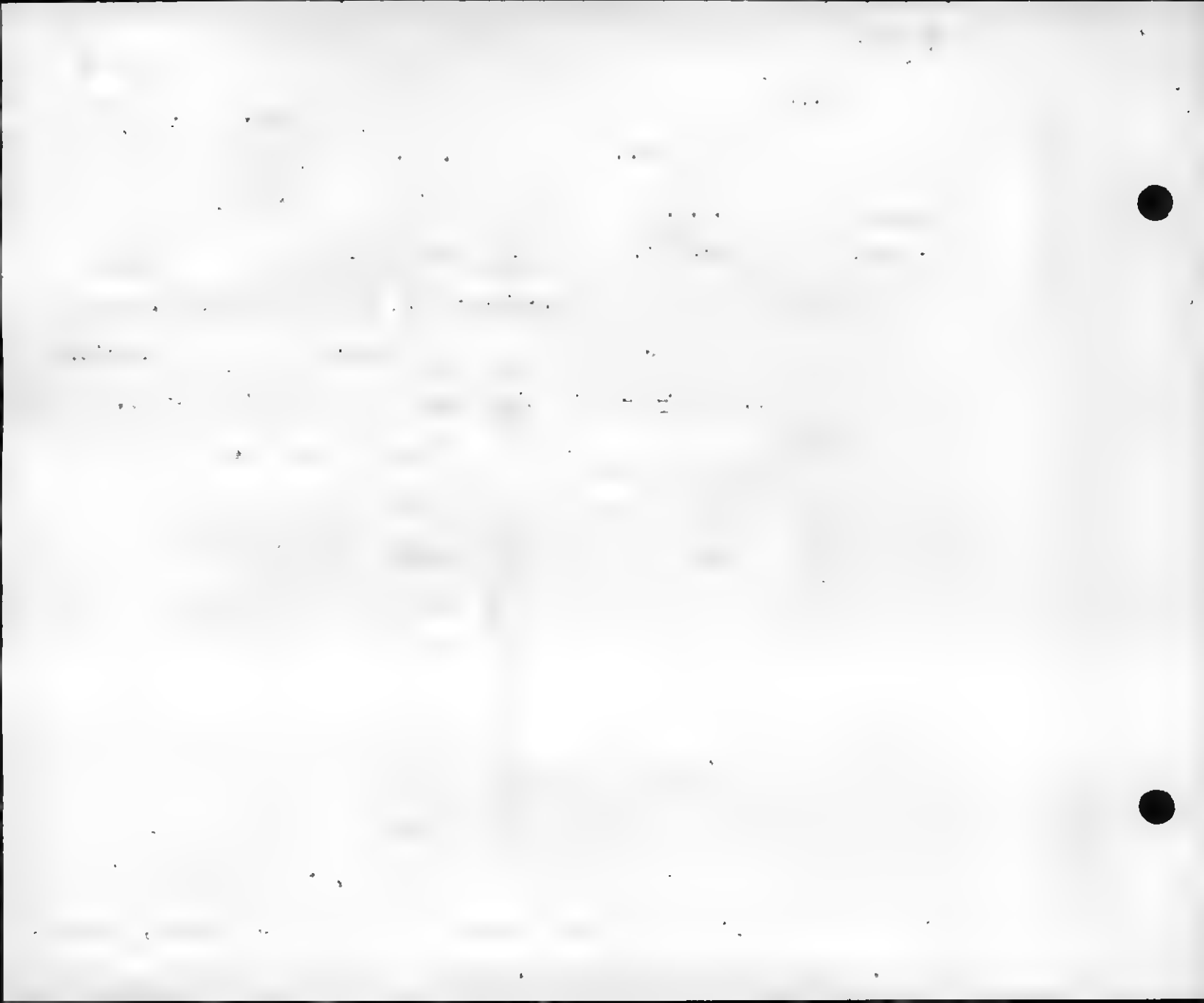


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VR A15(4)
30M REV 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|---|--|--|--|---|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1 DECEASED NAME
(Type or print) | | First Emma | | Middle | | Last Vogt | | 2a DATE OF DEATH
Month Feb. Day 9 Year 1968 | | 2b HOUR
7:45 PM |
| 3 SEX
Female | | 4 RACE
Caucasian | | 5 DATE OF BIRTH
Oct. 13, 1878 | | 6 AGE (n years last birthday)
89 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN |
| 7a BIRTHPLACE (State or foreign country)
Germany | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH
Baltimore | | Md | | |
| 10 CITY OR TOWN OF DEATH
Catonsville | | 11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)
Forest Haven Nursing Home | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Housewife | | 12b KIND OF BUSINESS OR INDUSTRY
Home | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE
Maryland | | 13b COUNTY
Baltimore | | 13c CITY OR TOWN
Baltimore | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER
1829 Duncan St. 21213 | | |
| 14 FATHER'S NAME First Adam Middle Gutberlet Last Theresa | | 15 MOTHER'S MAIDEN NAME First Eckstein Middle Eckstein Last Eckstein | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No (If yes give war or dates of service) | | 16b SOCIAL SECURITY NO
212-26-8848 | | 17. INFORMANT
Nick Borden | | Address
933 Cromwell Bridge Rd. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART 1. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) A.S.C.U.D.
4127 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____ DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
years |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4221 None | | | | | | | | | | |
| 19a. DATE OF OPERATION
— | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9 Feb , 19 68 , to 9 Feb , 19 68 , that (I) (we) last saw the deceased alive on 9 Feb , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b SIGNATURE
Ralph E. Updike MD | | DEGREE MD | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
11 Feb 68 | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Ralph E. Updike MD | | 22e. ADDRESS
31 Dogwood Dr. (21043) | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
2/12/1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Moreland Memorial | | 23d. LOCATION (City or Town) (County) (State)
Baltimore County, Maryland | | | | |
| 24 FUNERAL DIRECTOR
William E. Johnson | | ADDRESS
8521 Loch Raven Blvd. | | 25a REC'D BY REGISTRAR
21204 | | 25b REGISTRAR'S SIGNATURE
DATE FEB | | | | |

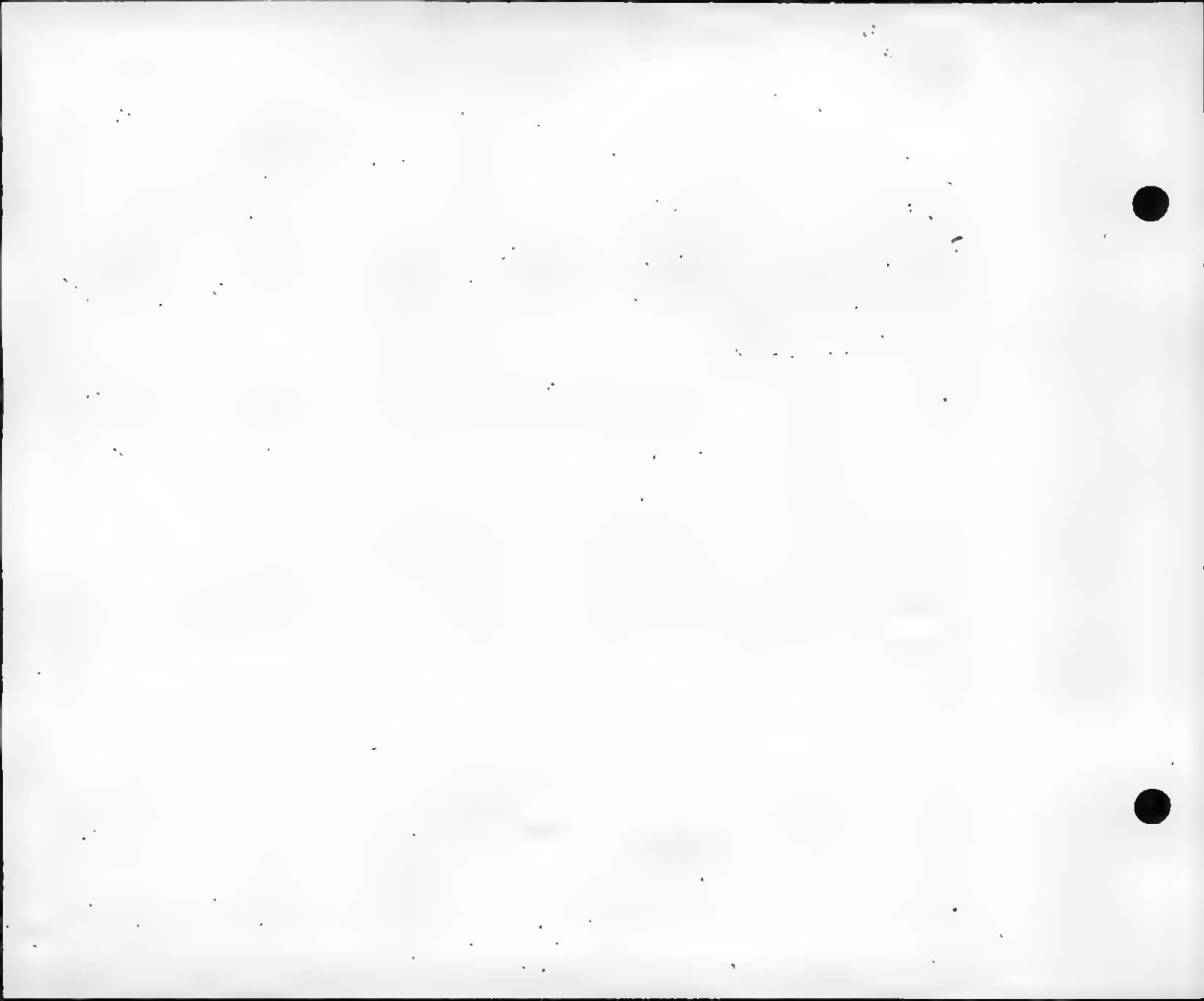


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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
|--|--|---|--|--|-------------------------------------|--|---|--|--|---|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1 DECEASED-NAME (Type or print) CHARLES H WAGNER | | | | | | 2a. DATE OF DEATH
Month 2 Day 22 Year 1968 | | | 2b. HOUR M | | | |
| 3 SEX MALE | | 4 RACE White | | 5. DATE OF BIRTH
Aug 16-1897 | | 6 AGE (In years last birthday) 70 YRS. | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | IF UNDER 24 HRS.
HOURS 0 MIN. 0 | | |
| 7a BIRTHPLACE (State or foreign country) MD | | 7b CIT ZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH BALTIMORE MD | | | | | | |
| 10 CITY OR TOWN OF DEATH Parkville | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2001 Taylor Ave | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE MD | | | 13b COUNTY BALTO | | 13c CITY OR TOWN Parkville | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER 2001 Taylor Ave | | | |
| 14 FATHER'S NAME First Henry Middle Wagner Last | | | | | | 15 MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service) | | | 16b SOCIAL SECURITY NO 412-09-4699 | | 17 INFORMANT Marion Snelling | | | Address Same | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RIGHT MIDDLE CEREBRAL ARTERY THROMBOSIS
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ARTERIOSCLEROSIS
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 wks
10 yrs | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e PLACE OF INJURY (At home farm street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County | | State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/28 , 19 57 , to 2/22 , 19 68 , that (I) (we) last saw the deceased alive on 2/22 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b SIGNATURE L.P. Bergen MD DEGREE | | | | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED 2/22/68 | | | | |
| 22d PHYSICIAN'S NAME (Type) L.P. Bergen | | | | | | 22e ADDRESS 8100 Hartford Rd | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b DATE 2/24/1968 | | 23c. NAME OF CEMETERY OR CREMATORY Meadow Ridge Cemetery | | 23d LOCATION (City or town) BALTO (County) MD (State) | | | | | | |
| 24 FUNERAL DIRECTOR Charles F. Evans & Son | | | | | | ADDRESS 8802 Hartford Rd | | 25a RECD BY REGISTRAR DATE FEB 26 1968 | | 25b REGISTRAR'S SIGNATURE Charles J. Jones | | |

MEDICAL CERTIFICATION

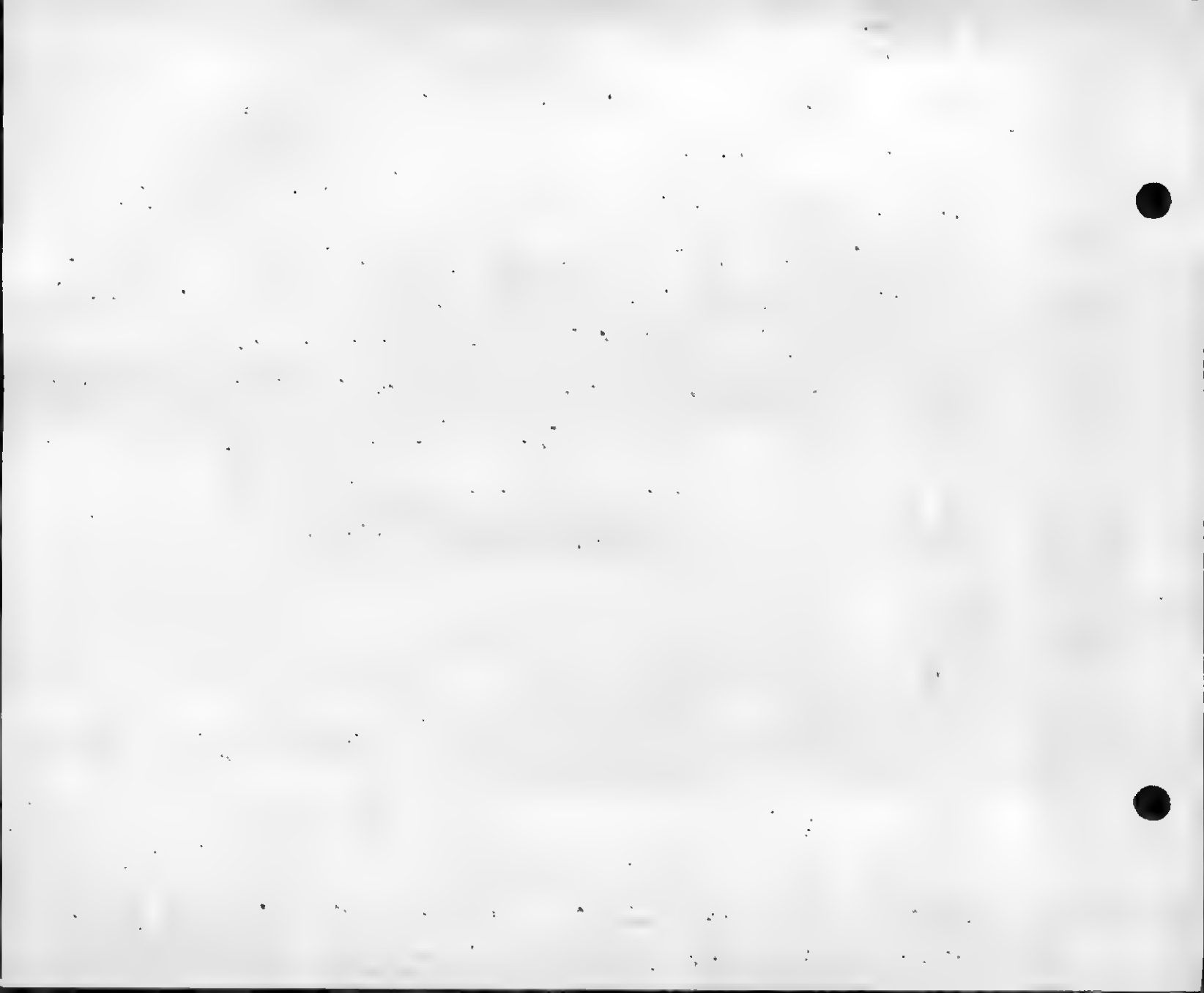


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--------|--|---|--|---|--|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| PAUL WILLIAM WAGNER | | | | | | Month Day Year
FEB 25 68 | | | 4:46 AM |
| 3 SEX | 4 RACE | | 5. DATE OF BIRTH | | | 6 AGE (In years last birthday) | | IF UNDER YEAR
MONTHS DAYS | |
| MALE | WHITE | | MAY 6, 1896 | | | 71 YRS. | | | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| CARROLL CO. MD. | | U.S.A. | | | | BALTIMORE Co. Md. | | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| OWINGS MILLS | | | 100 ENCHANTED HILLS ROAD | | | RAPID TRANSIT EMPLOYEE | | | |
| 13a USUA. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE | | | 13b COUNTY | | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| MARYLAND | | | BALTIMORE | | | OWINGS MILLS | | 13e STREET AND NUMBER | |
| | | | | | | | | 100 ENCHANTED HILLS ROAD | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| PETER S. WAGNER | | | ELIZABETH ANGELL | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT | | Address | | |
| | | | 213-10-1558 | | MRS. MATILDA C. WAGNER | | SAME ADDRESS | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| Coronary Thrombosis - acute | | | | | | | | | 3 hours |
| Arteriosclerosis - generalized | | | | | | | | | Years |
| Emphysema - Chronic | | | | | | | | | Years |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.) | | 21f LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from December, 1967, to February 25, 1968, that (I) (we) last saw the deceased alive on February 25, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE
CLARENCE E. MC-WILLIAMS | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c DATE SIGNED
2-25-68 | |
| 22d. PHYSICIAN'S NAME (Type)
CLARENCE E. MC-WILLIAMS | | | | | | 22e. ADDRESS
11904 Rostenstown Rd. Rostenstown Md. 21136 | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| BURIAL | | 2/27/68 | | ZION METH. CEM. | | WESTMINSTER RD. MD. | | | |
| 24. FUNERAL DIRECTOR
J.S. Myers, Jr. Westminster Md. | | | | | | 25a. REC'D BY REGISTRAR
DATE FEB 28 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Jones | |



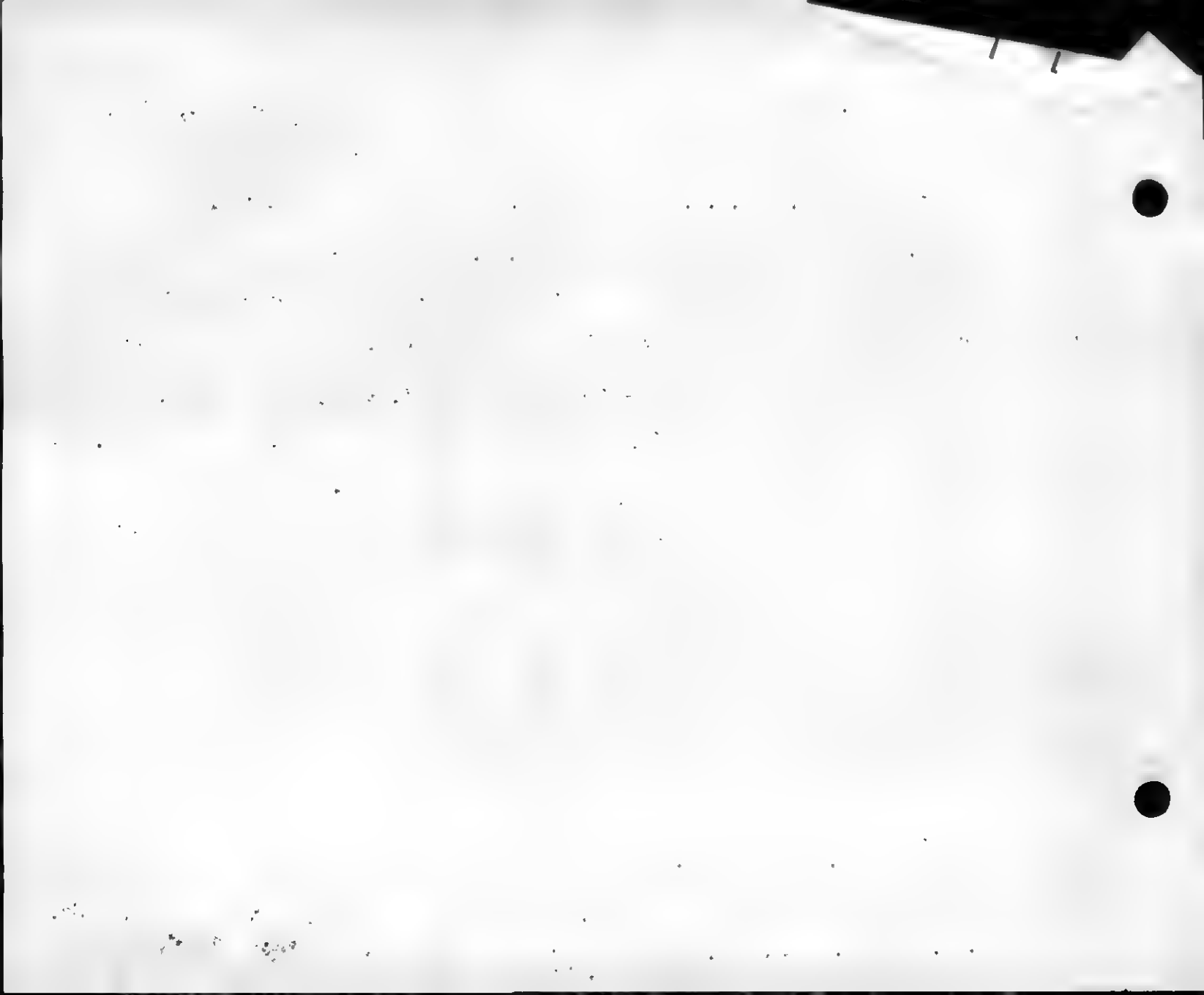
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VR A15 (4)
30M REV. 1/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | |
|---|---|--|--|---|--|
| 1 DECEASED-NAME (Type or print) First Middle Last
Margaret May Walker | | | 2a DATE OF DEATH Month Day Year
February 16, 1968 | | 2b HOUR
9:40 AM |
| 3 SEX
F | 4 RACE
W | 5 DATE OF BIRTH
October 29, 1878 | | 6 AGE (In years last birthday)
89 YRS | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN |
| 7a BIRTHPLACE (State or foreign country)
Baltimore, Md. | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
Baltimore Md | | |
| 10 CITY OR TOWN OF DEATH
Balto. 12 | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Armacost N. H. | | 12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)
Housewife | | 12b KIND OF BUSINESS OR INDUSTRY
Own Home |
| 13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | 13b COUNTY
Baltimore | 13c CITY OR TOWN
Baltimore | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET AND NUMBER
429 Kenneth Square | |
| 14. FATHER'S NAME First Middle Last
John Roberts | | 15. MOTHER'S MAIDEN NAME First Middle Last
Rosella Whitney | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)
No | | 16b SOCIAL SECURITY NO.
220-46-6696 | 17 INFORMANT Address
Miss Edith V. Walker (same) | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Recurrent cerebral thrombosis
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b) Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
(c) Arterial hypertension | | | | | BETWEEN ONSET AND DEATH
2 1/2 mos
18+ yrs
18+ yrs. |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from Apr 3, 1956 , to Feb 16, 1968 , that (I) (we) lost saw the deceased alive on Feb 13, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Frederick J. Vollmer DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED
Feb 17, 1968 | |
| 22d. PHYSICIAN'S NAME (Type)
Dr. Frederick J. Vollmer | | 22e. ADDRESS
6100 York Road | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE
2/19/68 | 23c. NAME OF CEMETERY OR CREMATORY
Western | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Md. | |
| 24. FUNERAL DIRECTOR
H. W. Jenkins & Sons Co. 4905 York Road Baltimore Md. 21212 | | 25a. REC'D BY REGISTRAR
DATE FEB 19 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles J. [Signature] | |

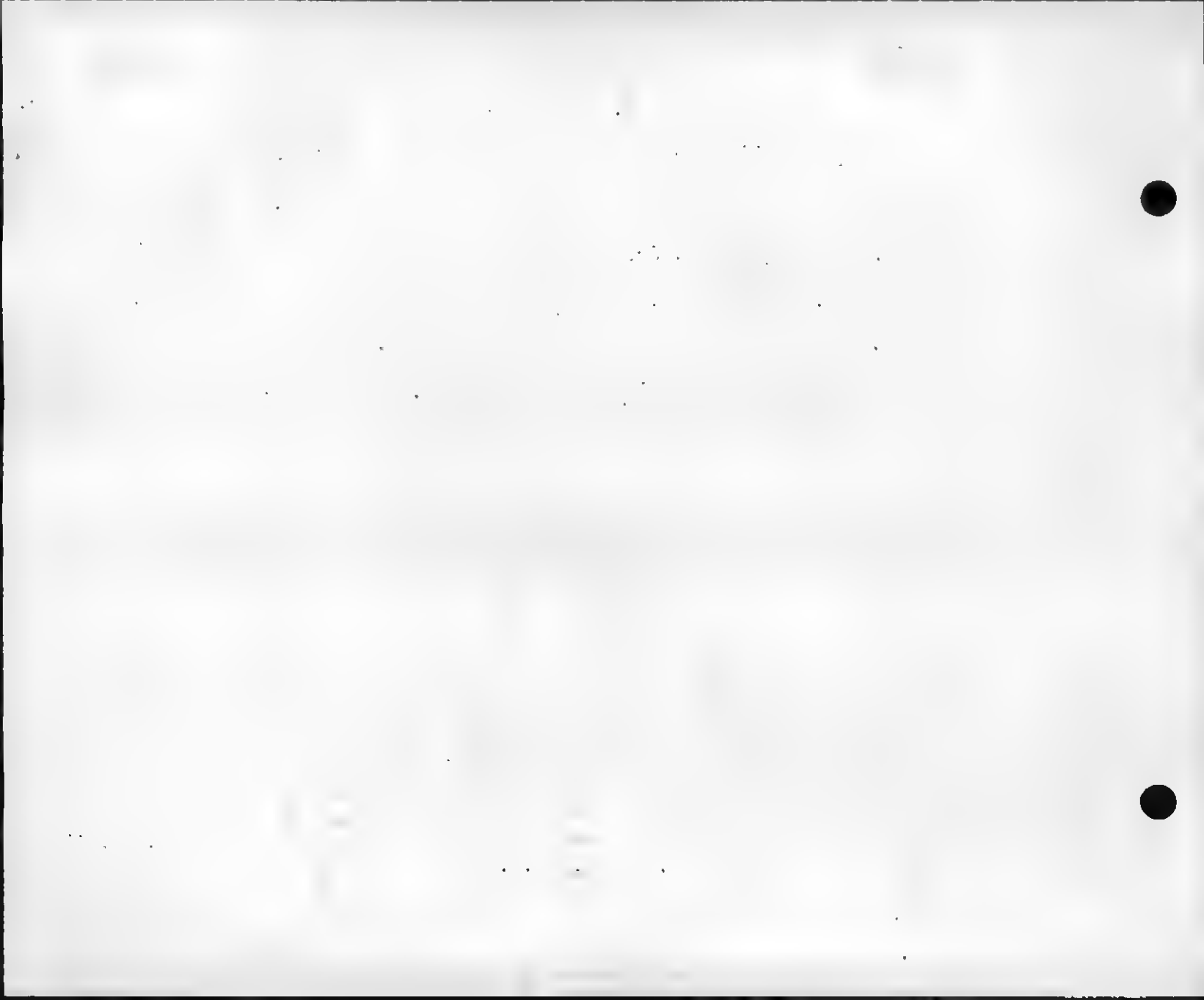


FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|---------|-----------------------------|--|--|---|--|---|--------------------|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1 DECEASED NAME
(Type or Print) | | | First | | | Middle | | | Last | | |
| JOHN | | | R. | | | WALTERS | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN | |
| Male | | White | | March 22, 1943 | | 24 YRS | | | | | |
| 7a BIRTHPLACE (State or foreign country) | | | 7b CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | 9. COUNTY OF DEATH | | |
| Maryland | | | USA | | | | | | Balto. | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | |
| Balto. | | | | St. Joseph Hospital | | | | Electronic Repairman | | | |
| 13a U.S.A. RESIDENCE (Where deceased lived, if institution residence before admission) STATE | | | | 13b. COUNTY | | | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| Md. | | | | Balto. | | | | Balto. | | 3105 Vulcan Rd. | |
| 14 FATHER'S NAME | | | | | | 15 MOTHER'S MAIDEN NAME | | | | | |
| John R. Walters | | | | | | Vivian C. Vest | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | | | 16b SOCIAL SECURITY NO | | 17 INFORMANT ADDRESS | | | |
| Yes | | | | | | 715164 to 7166 217 40 3965 | | Bernard J. Zorn 3105 Vulcan Road | | | |
| 18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocarditis | | | | | | | | | | | |
| 428X DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | 21b TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | M.D. | | 22b DATE SIGNED | | | |
| EXAMINER'S NAME (Type) | | | | | | Edward F. Wilson, M.D. | | Feb. 28, 1968 | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | | | | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | |
| Burial | | | | | | 3-2-68 | | Gardens of Faith Cemetery | | Baltimore, Maryland | |
| 24 FUNERAL DIRECTOR | | | | | | ADDRESS | | 25a REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | |
| Walter E. Crach | | | | | | 1211 Chesaco Avenue | | MAR 1 1968 | | Charles J. Jones | |



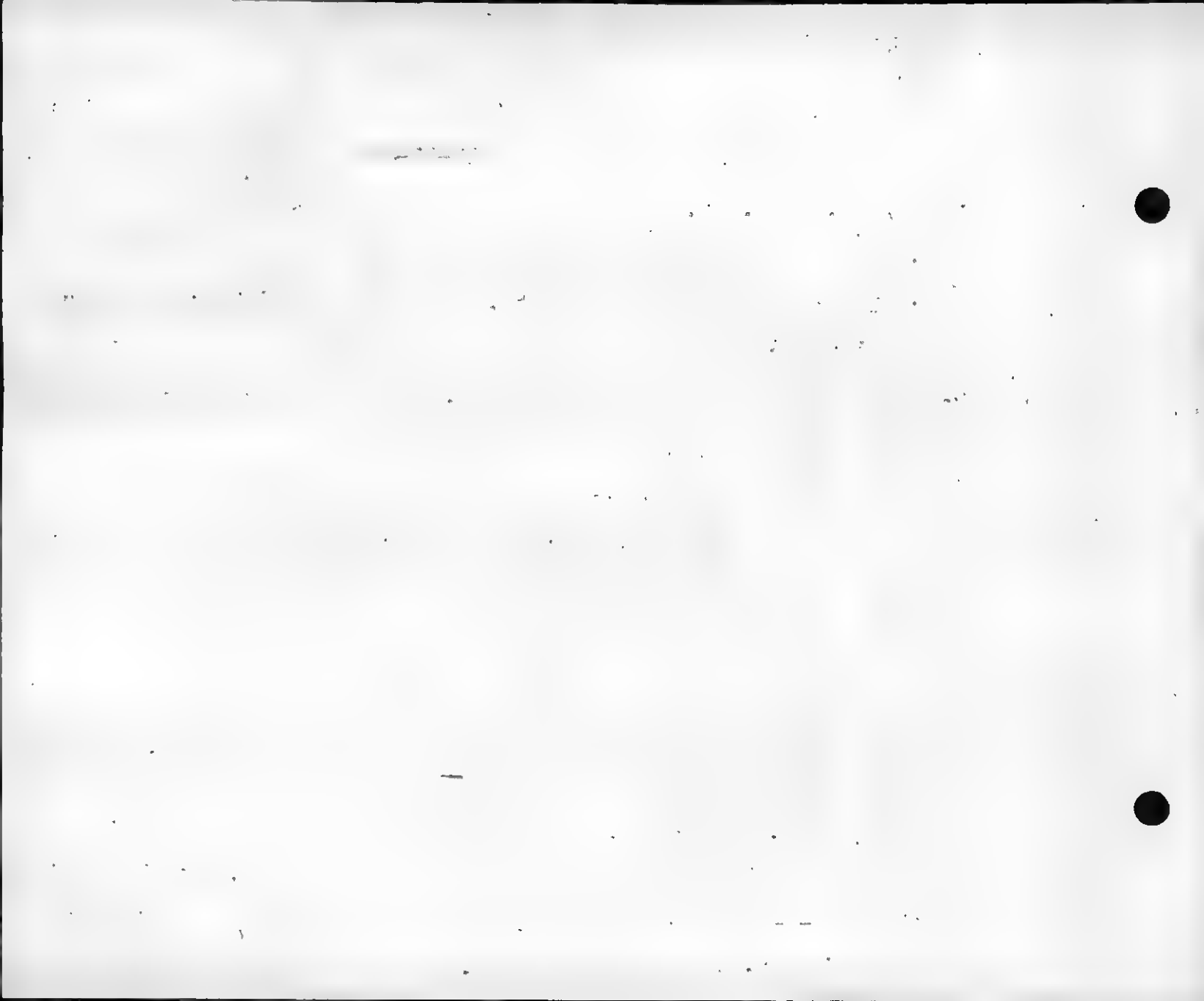
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12387

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | |
|--|--------|---|-----------------|--|--------------------------------|--|-----------------------|--|
| 1 DECEASED NAME
(Type or print) | | First | Middle | Last | 2a DATE OF DEATH | | 2b HOUR | |
| Dora | | | | Ward | 2 Month 2 Day 68 Year | | 2:06 P.M. | |
| 3 SEX | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (In years lost birthday) | | 7 UNDER 1 YEAR | |
| Female | Negro | | 12-17-1901 | | 66 YRS | | MONTHS DAYS HOURS MIN | |
| 7a BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | |
| Norfolk, Va. | | U.S.A. | | | | Towson Md | | |
| 10. CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Towson | | Greater Balto Med Center | | None | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution admission) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER |
| Maryland | | | | Balto. | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 3505 Plateau Avenue |
| 14 FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | Address | | | | |
| First Middle Last | | First Middle Last | | | | | | |
| CALOB KEYS | | MARY KEYS | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT | | Address | | |
| No. | | | | Rev. H. Ward | | 3505 Plateau Avenue | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Uremia</u> | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | |
| (b) <u>Renal failure</u> | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| (c) <u>Arteriosclerotic cardiovascular disease & diabetes mellitus</u> | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | Yes | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | |
| | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f. LOCATION | | City or Town | | County State |
| | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 10</u> , 19 <u>68</u> , to <u>Feb 2</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Feb 2</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYS. | | MED. DIRECTOR | | STAFF PHYS. |
| <u>John E. Adams</u> | | | | <input type="checkbox"/> | | <input type="checkbox"/> | | <input checked="" type="checkbox"/> |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | 22c. DATE SIGNED | | | | |
| John E. Adams, M.D. | | 6701 N. Charles St. Towson, Md. | | 2/3/68 | | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) (State) |
| Burial | | 2-7-68 | | Greater Sweet Beulah | | Sulfolk | | Virginia |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. RECD BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| MORTON & DYETT F.H. | | 1701 Laurens St. | | FEB 7 1968 | | <u>Charles Judge</u> | | |

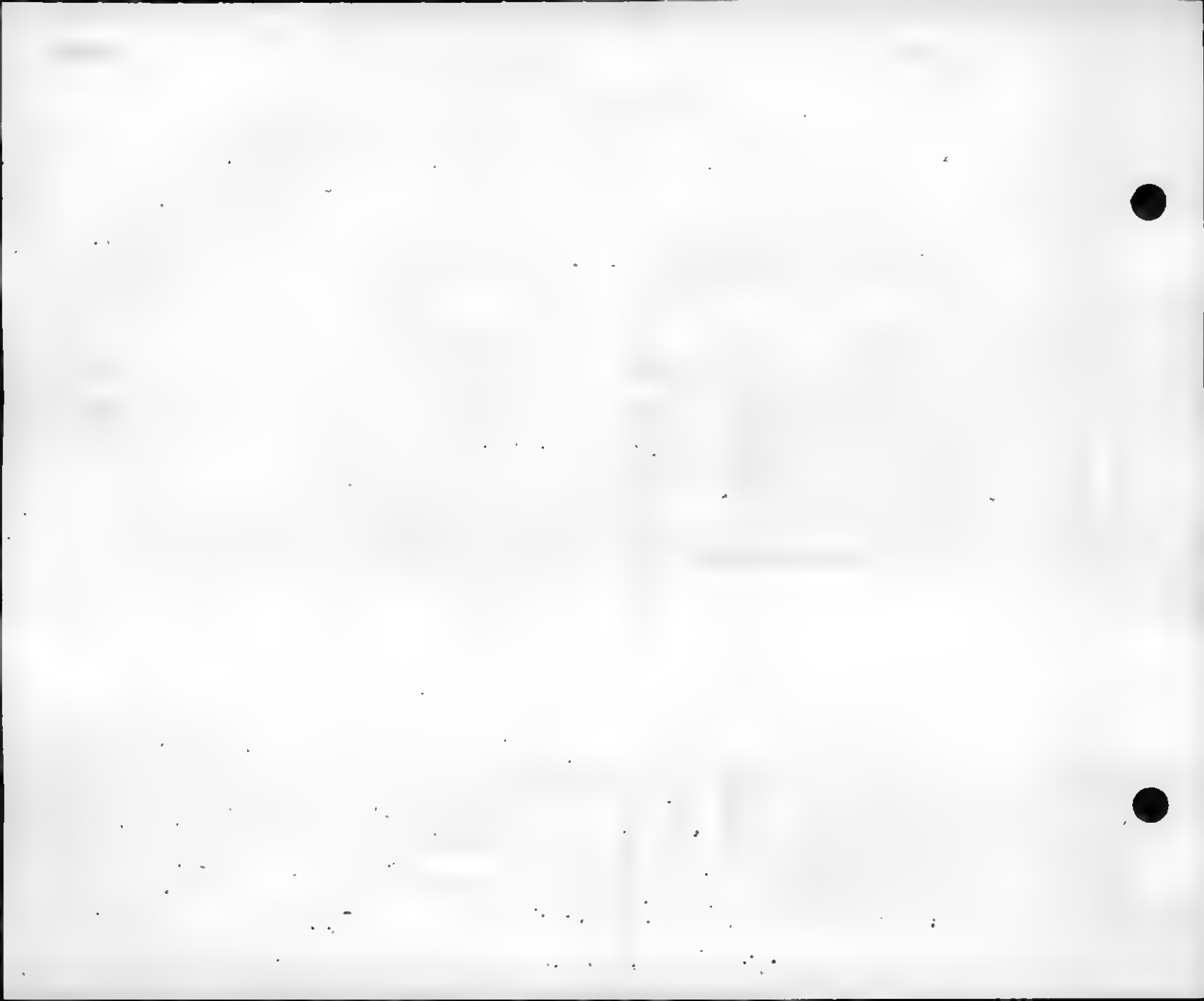


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111111 Items 7a, 7b, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

| | | | | | | | | | | | |
|---|--|--|--------------------------|---|------------------------|---|--|--|----------|--|------|
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| Everett | | | Andrew | Warren | Month 2 Day 25 Year 68 | | | 5:35pm | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Male | | Cau | | 8/18/67 | | 6 months | | MONTHS 6 DAYS 7 HOURS MIN | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Maryland | | | | | | Baltimore | | Md | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Baltimore | | Greater Baltimore Med. Center | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Maryland | | Baltimore | | | | | | 1282 Woodbourne Avenue | | | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last |
| Everett Paul Warren | | | | | | Patricia Margaret Mosiej | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | |
| | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congenital hydrocephalus | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | | |
| | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | | | |
| 21d. INJURY OCCURRED <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County State | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/20, 1968, to 2/25, 1968, that (I) (we) last saw the deceased alive on 2/25, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE R. Breitenacker, M.D. | | | | | | | | 22c. DATE SIGNED 2/25/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) R. Breitenacker, M.D. | | | | | | | | 22e. ADDRESS 6701 N. Charles Street | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE 2/27/68 | | 23c. NAME OF CEMETERY OR CREMATORY GIBMC | | 23d. LOCATION (City or Town) (County) (State) Towson, MD, 21204 | | | | | |
| 24. FUNERAL DIRECTOR R. Breitenacker | | ADDRESS GIBMC | | 25a. REC'D BY REGISTRAR DATE 12 1968 | | 25b. REGISTRAR'S SIGNATURE | | | | | |

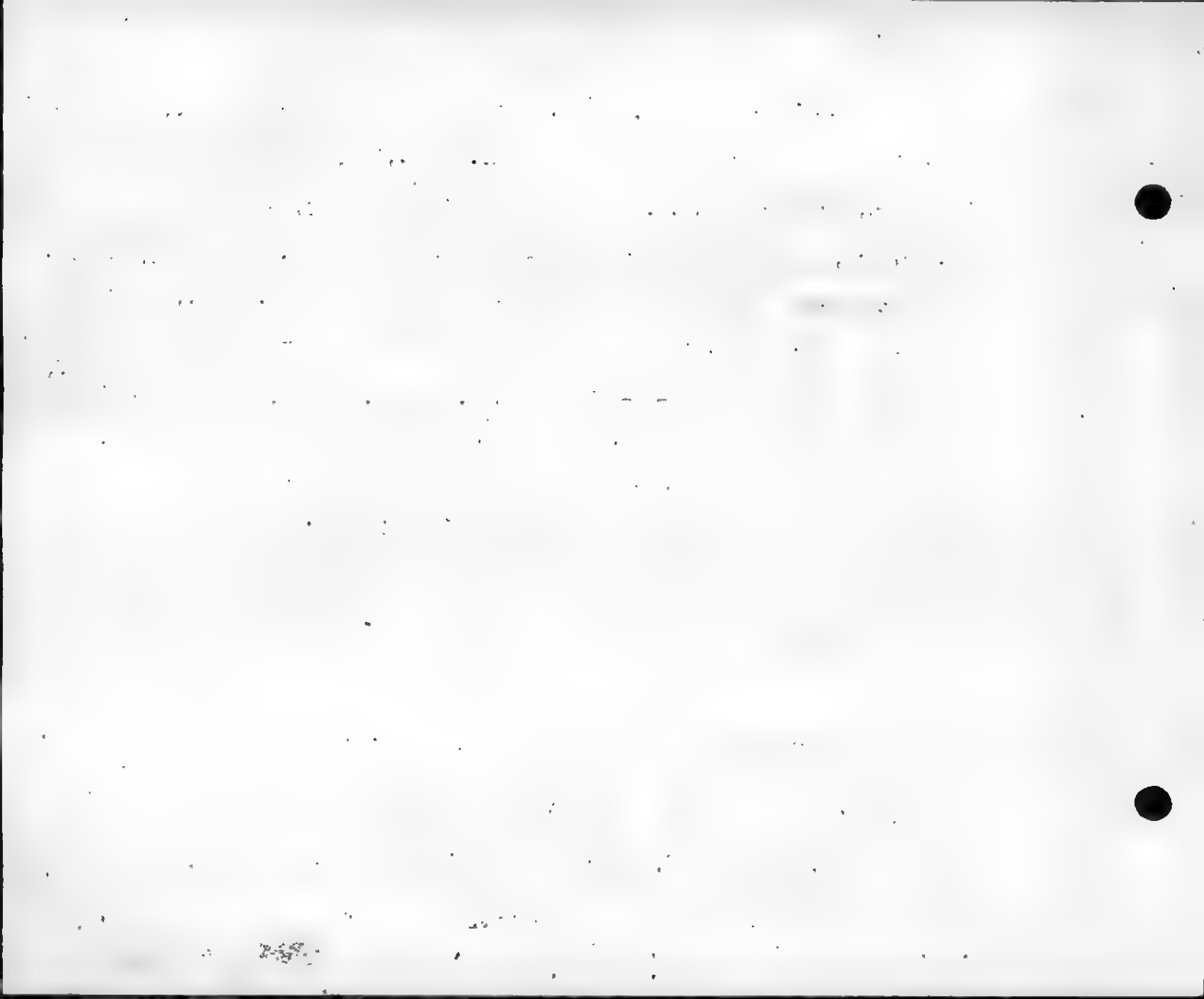


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | |
|--|-------------------------|--|--|---|--|
| 1 DECEASED NAME
(Type or print) MARGUERITE E. WATERS | | | 2a DATE OF DEATH
Month February Day 20th , Year 1968 | | 2b. HOUR
2:15 P.M. |
| 3 SEX
Female | 4. RACE
White | 5 DATE OF BIRTH
Dec. 21st., 1881 | | 6 AGE (In years last birthday)
86 YRS. | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 |
| 7a BIRTHPLACE (State or foreign country)
Baltimore, Maryland | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. COUNTY OF DEATH
Baltimore | | 10 CITY OR TOWN OF DEATH
Lutherville. | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
College Manor Nursing Home | |
| 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Saleslady | | 12b KIND OF BUSINESS OR INDUSTRY
Retired-Sales | | 13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE
New York | |
| 13b COUNTY
New York | | 13c CITY OR TOWN
New York | | 13d INSIDE CITY (J.M.T.S.)
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e STREET AND NUMBER
132 E. 54th., Street | | 14 FATHER'S NAME
First Robert Eugene Middle Waters Last | | 15 MOTHER'S MAIDEN NAME
First Mary Middle Henrietta Last Tubman | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No | | 16b SOCIAL SECURITY NO
088-09-6319 | | 17 INFORMANT
Atty: Mr. John T. Kenney, Mercantile Safe & Trust | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) congestive heart failure
1409
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) pneumonia + arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) generalized arteriosclerosis | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 day
2 wks
years |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | |
| 21b. TIME OF INJURY
HOUR A.M. Month Day Year 19
P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, etc.)
 | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-5-55 , 19 55 , to 2-20 , 19 68 , that (I) (we) last saw the deceased alive on 2-13 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
William F. Fritz M.D. DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2/20/68 | |
| 22d. PHYSICIAN'S NAME (Type)
Dr. William F. Fritz | | 22e. ADDRESS
2 W. University Pkwy. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
2/23/68 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral | |
| 23d. LOCATION (City or Town)
Baltimore | | (County)
Md. | | (State)
Md. | |
| 24. FUNERAL DIRECTOR
H. W. Jenkins & Sons Co. | | ADDRESS
4905 York Rd. Balto. 12, Md. | | 25a. REC'D BY REGISTRAR
FEB 21 1968 | |
| 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

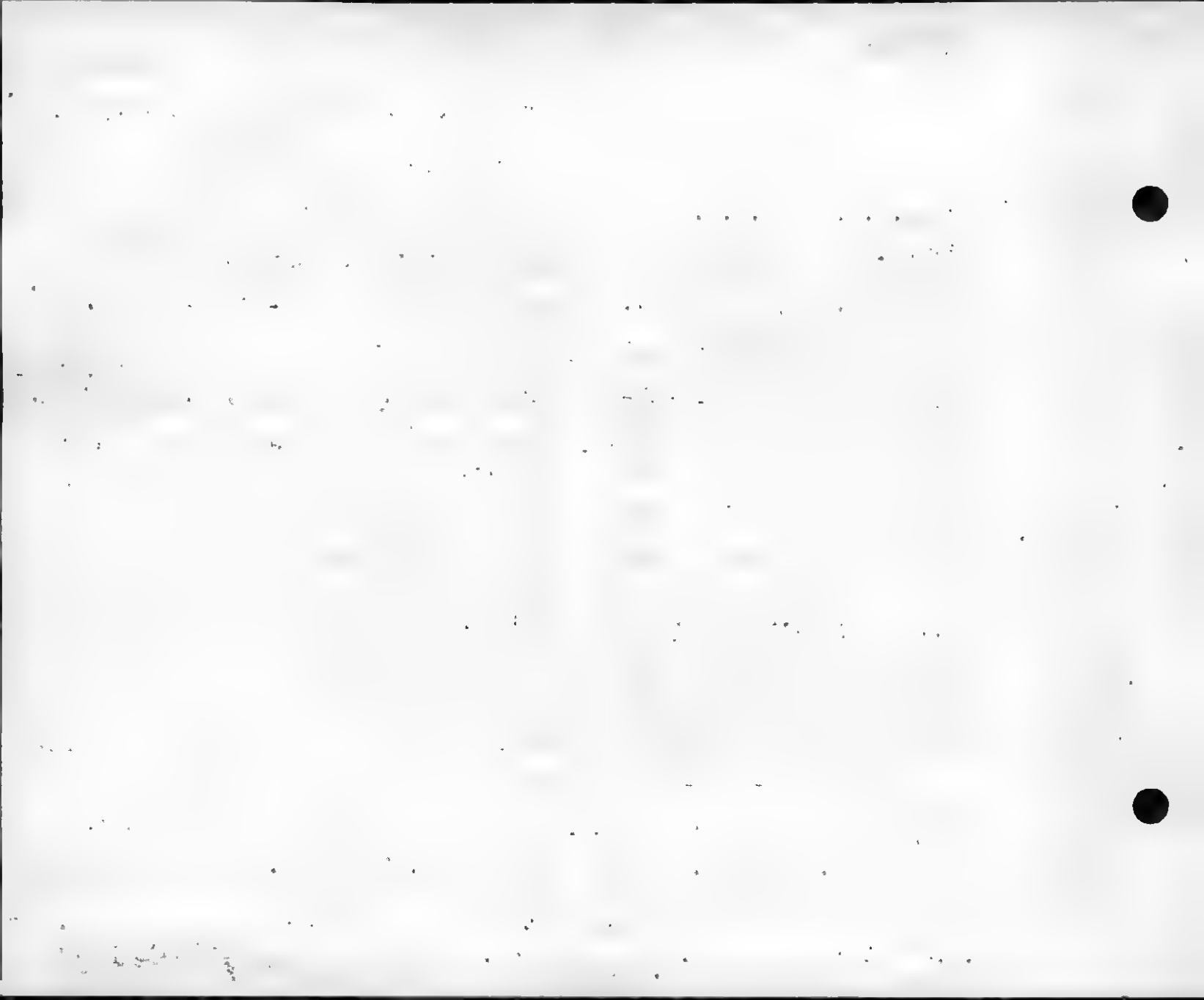


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled up, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|---|--|---|---|--|--|--|--|---|--|
| 1. DECEASED-NAME
(Type or print) William Nicklin Watmough, Jr. | | | 2a. DATE OF DEATH
Month February Day 13 Year 1968 | | | 2b. HOUR 8:30 A.M. | | | | | |
| 3. SEX M | | 4. RACE W | | 5. DATE OF BIRTH
4/6/1901 | | 6. AGE (in years last birthday)
66 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
Wash. D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Ruxton | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
7901 Bellona Ave. | | | 12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired)
Executive Davidson Chemical | | | 12b. KIND OF BUSINESS OR INDUSTRY
Co. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Md. | | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Ruxton | | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 13e. STREET AND NUMBER
7901 Bellona Ave. | | |
| 14. FATHER'S NAME First William Middle Nicklin Last Watmough | | | | 15. MOTHER'S MAIDEN NAME First Mary Middle Davidson Last Davidson | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO
213-01-6390 | | 17. INFORMANT Address 1445 Md. Nat'l Bank Bldg.
Harrison M. Robertson, Jr. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the pancreas with metastasis to the liver
DUE TO, OR AS A CONSEQUENCE OF (b) the liver
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
About 4 months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION
11/10/67. | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Liver biopsy, Gastrojejunostomy, Exploratory laparotomy. | | | | 20a. AUTOPSY? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. 19 Month 19 Year 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21a. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21b. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21c. LOCATION Street or R.F.D. No City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/11/32 , 19 , to 2/13/68 , 19 , that (I) (we) lost saw the deceased alive on 2/9/68 , 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Edwin B. Jarrett, M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED
2/14/68. | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Dr. Edwin B. Jarrett | | | | | | 22e. ADDRESS
11 E. Chase St. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
2/14/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Greenmount | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | | | | | |
| 24. FUNERAL DIRECTOR
H.W. Jenkins & Sons Co. ADDRESS 4905 York Rd. Balto. 12, Md. | | | | | | 25a. REC'D BY REGISTRAR
DATE FEB 15 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|--|---|---|--|--|--|-------------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | | Middle | | Last | | 20. DATE OF DEATH
Month Day Year | | |
| Alice | | | B. | | Watson | | Feb 22 | | 1968 114. AM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (n years last birthday) | | 7. UNDER 1 YEAR
MONTHS DAYS | | |
| Female | | White | | 11-8-1908 | | | 59 YRS. | | 1 UNDER 24 HRS
HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Maryland | | U.S.A. | | | | Baltimore Md | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Lansdowne | | | 3212 Rosalie Rd. 21227 | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Maryland | | | Balto. | | Lansdowne | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 3212 Rosalie Road | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| John Bowen | | | Edythe Muhles | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT Address | | | | | | |
| | | | 213-03-3588 | | Mr. James A. Watson, Jr. 3212 Rosalie Rd. 21227 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Arteriosclerotic heart disease with congestive heart failure</i> | | | | | | | | | | 6 years - | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>unknown</i> | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic Bronchitis</i> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| <i>Chronic Bronchitis</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR AM Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>7/14, 1967</i> to <i>2/22, 1968</i> , that (I) (we) last saw the deceased alive on <i>2/9, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>Cesar J. Pellerano</i> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22c. DATE SIGNED <i>2-23-68</i> | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <i>Dr. Cesar J. Pellerano</i> 22e. ADDRESS <i>13311 Glenmont Rd / 2436 Washington Blvd.</i> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | 2-26-1968 | | Loudon Park Cemetery | | Baltimore, Maryland | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | | FEB 29 1968 | | <i>Charles Judge</i> | | | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

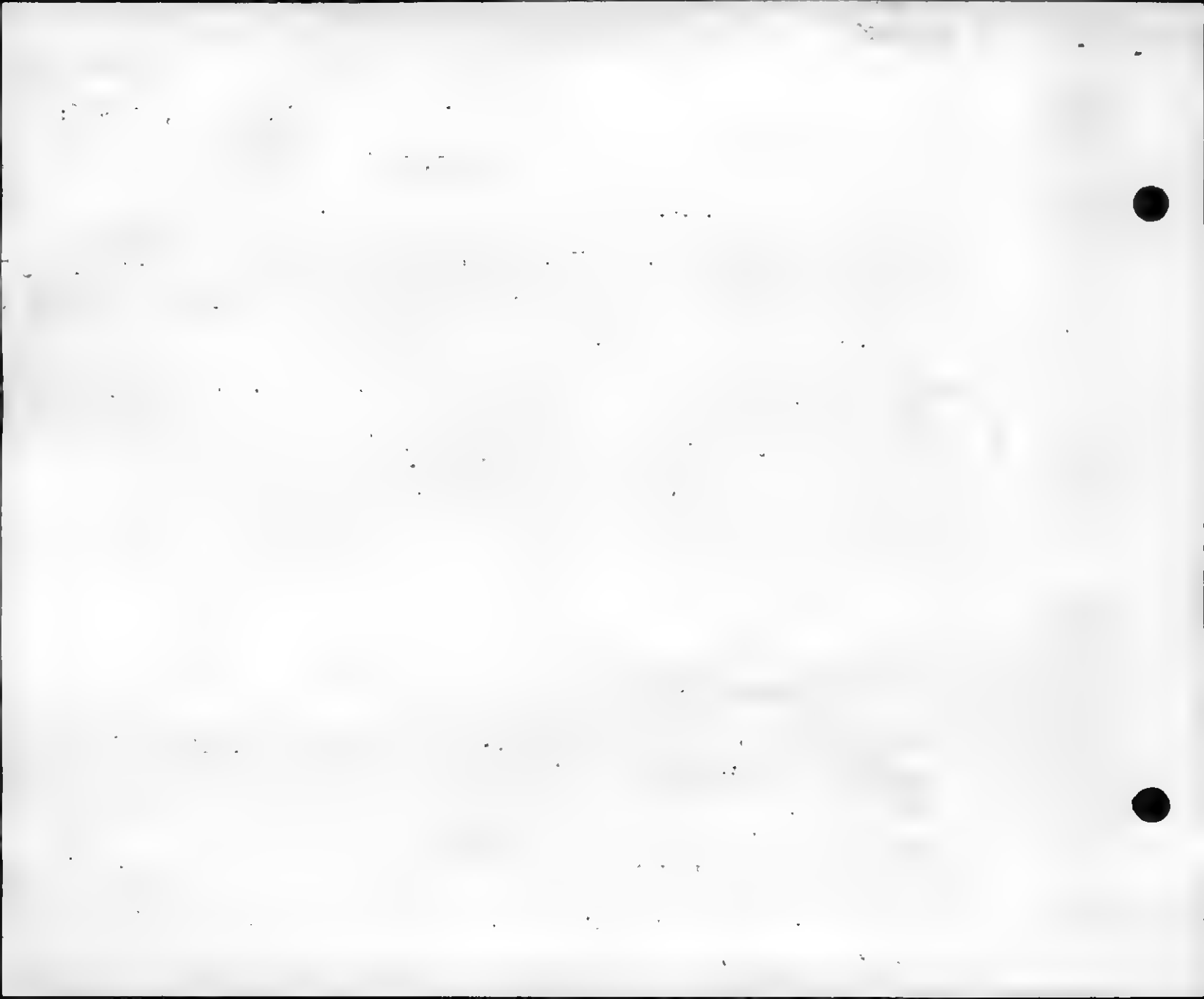
VR A15 (4)
30M REV 1/68

MD 892
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02372

| | | | | | |
|---|--|--|--|--|---|
| 1 DECEASED NAME
(Type or print) First Middle Last
ALEX WEINER | | | 2a DATE OF DEATH
Month Day Year
FEBRUARY 12, 1968 | | 2b HOUR
Min
6:35 A.M. |
| 3 SEX
MALE | 4 RACE
WHITE | 5 DATE OF BIRTH
MAY 31, 1924 | | 6 AGE (In years last birthday)
43 YRS. | 7 UNDER 1 YEAR
MONTHS DAYS
43 |
| 7a BIRTHPLACE (State or foreign country)
MARYLAND | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
BALTIMORE | | 10. CITY OR TOWN OF DEATH
TOWSON |
| 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
ST. JOSEPH HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
PHARMACIST | | 12b. KIND OF BUSINESS OR INDUSTRY
LYKOS PHARMACY | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE
MARYLAND | | 13b COUNTY
BALTIMORE | 13c CITY OR TOWN
BALTIMORE | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e STREET AND NUMBER
3116 LIGHTFOOT DRIVE #21208 |
| 14 FATHER'S NAME First Middle Last
ABRAHAM WEINER | | 15 MOTHER'S MAIDEN NAME First Middle Last
SARAH BULNASH | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) (If yes give war or dates of service)
YES U.S. 11 | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT Address
MRS. BARBARA WEINER, 3116 LIGHTFOOT DR. #21209 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ruptured anterior communicating artery aneurysm and
DUE TO, OR AS A CONSEQUENCE OF intercranial hemorrhage
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
(c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a DATE OF OPERATION | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | 21b TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21a INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f. LOCATION Street or R.F.D. No. | City or Town | County State |
| 22a I certify that (I) (this hospital) attended the deceased from JANUARY 30, 1968 , to FEBRUARY 12, 1968 , that (I) (we) last saw the deceased alive on FEBRUARY 12, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Jaime Ambrad</i> | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | 22c. DATE SIGNED
2-12-68 | |
| 22d. PHYSICIAN'S NAME (Type)
Jaime Ambrad, M.D. | | | 22e ADDRESS
7620 York Road, Baltimore, Md. 21204 | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE
2-13-68 | 23c NAME OF CEMETERY OR CREMATORY
BETH YEHUDA ANSHE KURLAND | | 23d LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | |
| 24. FUNERAL DIRECTOR ADDRESS
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | | 25a. REC'D BY REGISTRAR
DATE FEB 13 1968 | 25b. REGISTRAR'S SIGNATURE | |



MARYLAND STATE DEPARTMENT OF HEALTH

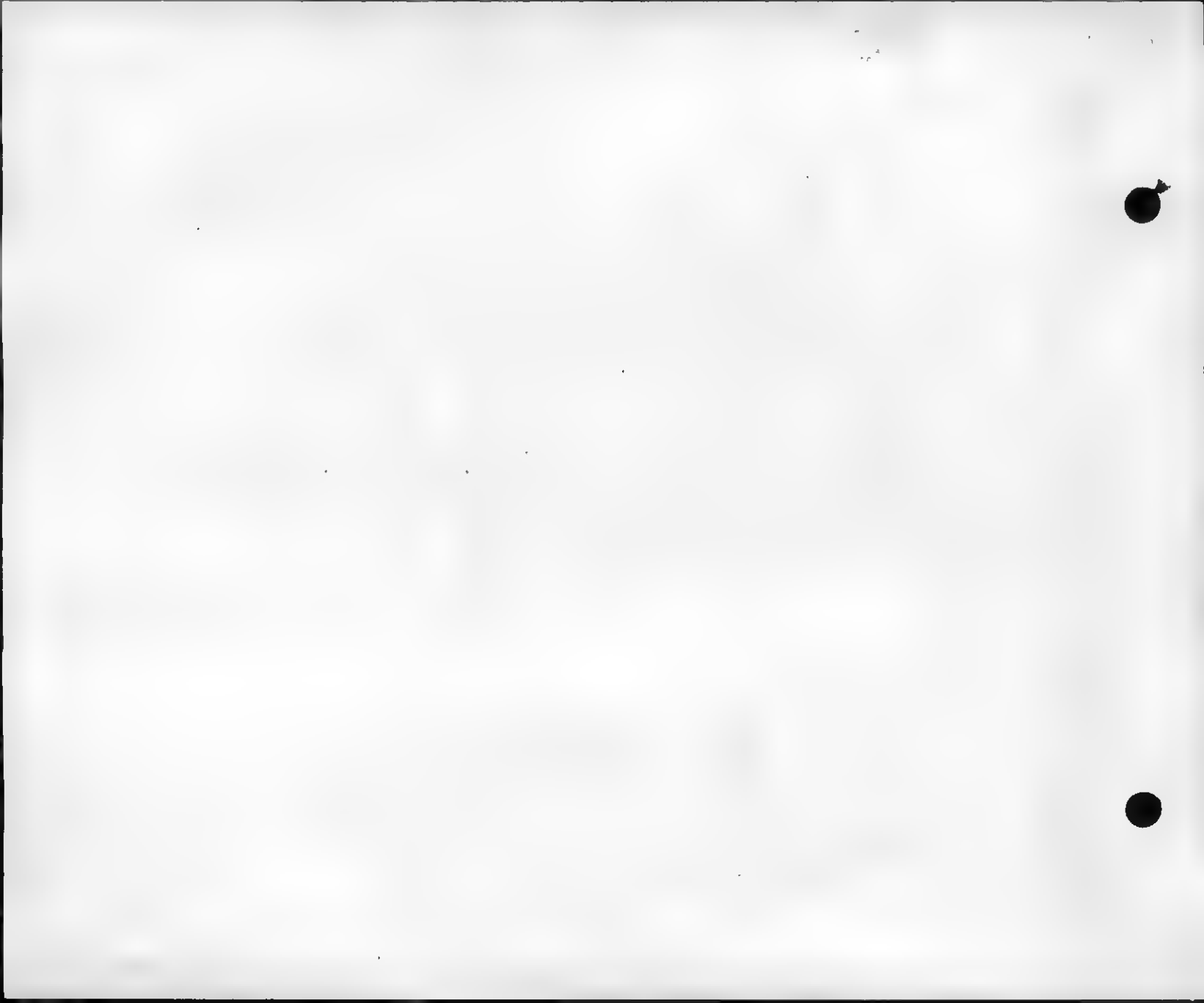
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 2 Film G398 3/15/68 kk

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

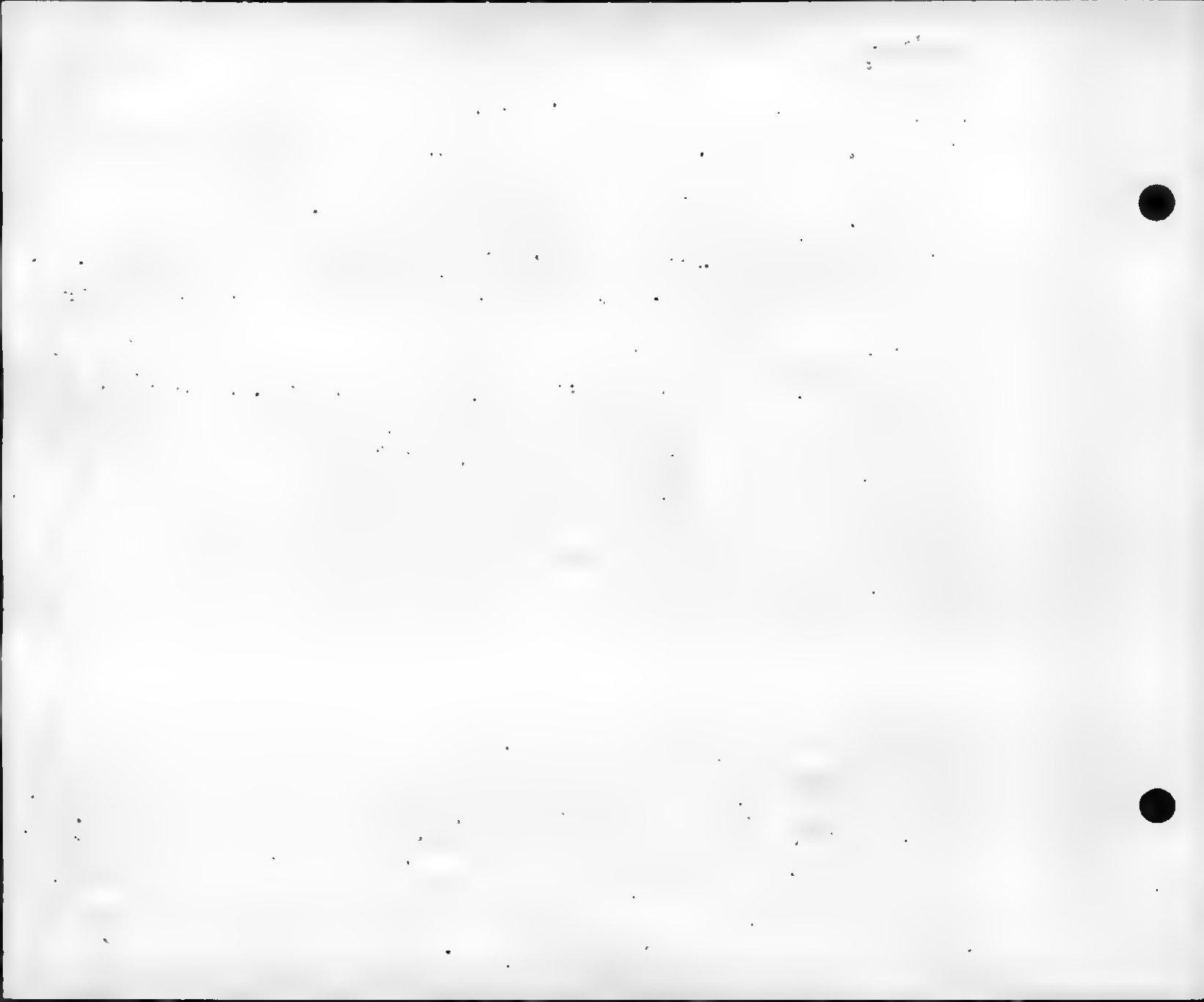
| | | | |
|--|--|--|--|
| 1 PLACE OF DEATH
a. COUNTY BALTIMORE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PIKESVILLE
c. LENGTH OF STAY IN 7b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Melford Manor Nursing Home | | 2 USUAL RESIDENCE (Where deceased lived if institution on Residence before admission)
a. STATE MARYLAND
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PIKESVILLE Baltimore
d. STREET ADDRESS 5819 Oakland Road
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) Fannie Wellemen
First Middle Last
5 SEX Female
6 COLOR OR RACE White
7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8 DATE OF BIRTH 12-22-1877
9 AGE (In years and months) 90
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES LADY
10b. KIND OF BUSINESS OR INDUSTRY RETIRED
11 BIRTHPLACE (County & State or foreign country) BALTIMORE, MARYLAND
12 CITIZEN OF WHAT COUNTRY? U.S.A. | | 4 DATE OF DEATH 12 28 1968
Month Day Year
13. FATHER'S NAME Isaac Wellemen
14. MOTHER'S MAIDEN NAME Rosa Senker
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
16. SOCIAL SECURITY NO. 212-09-9421
17. INFORMANT MRS. ESTHER R. KOPPELMANN
Address 5819 OAKLAND RD. #27 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4101 DUE TO Cardiovascular C.V.D.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Recurrent asthma, coronary artery disease
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 12-28-1968 to 12-28-1968 , that (I) (we) last saw the deceased alive on 12-28-1968 , and that death occurred at 11 AM , from causes and on the date stated above.
22a. SIGNATURE Joseph B. Gross
22c. PHYSICIAN'S NAME (Type) Joseph B. Gross
22d. ADDRESS 6911 Park Heights C
22b. DATE SIGNED | | 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE THEREOF 3-1-68
23c. NAME OF CEMETERY OR CREMATORY HEBREW FRIENDSHIP
23d. LOCATION (City or town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR 501 Levinson & Bros.
ADDRESS 6010 REISTERSTOWN ROAD
25a. RECD BY REGISTRAR DATE MAR 1 1968
25b. REGISTRAR'S SIGNATURE Charles J. [Signature] | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|--|--|--|---|---|--|--|---|--|--|--------------------------------|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED NAME
(Type or print) Blanche Wessel | | | | | | 2a. DATE OF DEATH
Month 2 Day 3 Year 68 | | | 2b. HOUR
4:10 A.M. | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
8/10/95 | | | 6. AGE (In years last birthday)
72 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS M.N. |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md | | | | | |
| 10. CITY OR TOWN OF DEATH
Owings Mills | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Rosewood State Hosp | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
none | | | 12b. KIND OF BUSINESS OR INDUSTRY
none | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE
Md. | | | 13b. COUNTY
Baltimore Balto. | | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
2992 Laurel St. SPANISH CREEK, THOMP. | |
| 14. FATHER'S NAME First Middle Last
William J. Wessel | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Eubain AtKins | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) no | | | 16b. SOCIAL SECURITY NO.
218-54-0505 | | 17. INFORMANT Address
Rosewood Records, Owings Mills, Md. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Pulmonary Edema
DUE TO, OR AS A CONSEQUENCE OF
(b) Acute Pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Dysphagia | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(f either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb. 2, 1968 , to Feb. 3, 1968 , that (I) (we) last saw the deceased alive on Feb. 3, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Remzi Demir, M.D. | | | | | | DEGREE | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
Feb. 3, 68 | |
| 22d. PHYSICIAN'S NAME (Type)
REMZI M. DEMIR, M.D. | | | | | | 22e. ADDRESS
Rosewood Box 200 Owings Mills, Md. 21117 | | | | | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) | | 23b. DATE
2/6/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Maryland | | | | |
| 24. FUNERAL DIRECTOR
Robert C. Altenburg Funeral Home, Inc. | | | | | | ADDRESS
6009 Harford Rd. - Balto., Md. 21214 | | 25a. RECD BY REGISTRAR
FEB 7 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

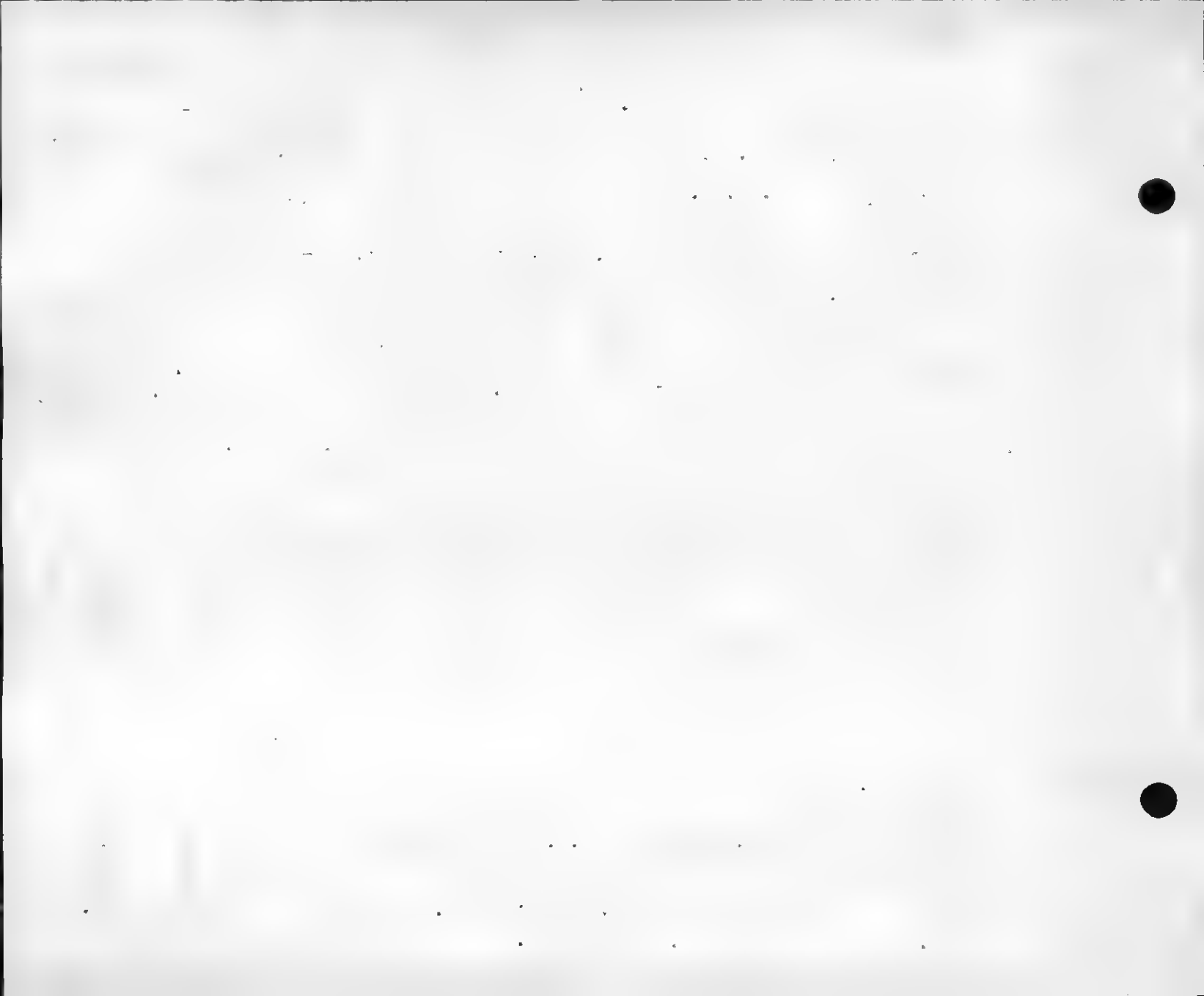


FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1-413. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
|--|--|-----------------------------|-------|--|--|--------------------------------|--|---|------|----------------|--|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1 DECEASED-NAME (Type or Print) | | | First | | | Middle | | | Last | | | | |
| ROBERT | | | M. | | | WHITE | | | | | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (In years last birthday) | | IF UNDER 1 YEAR | | F UNDER 24 HRS | | | |
| Male | | White | | Nov. 16, 1923 | | 44 YRS | | MONTHS | | DAYS | | | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | 2a DATE KNOWN OF DEATH | | 2b HOUR | | | |
| Virginia | | U. S. A. | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | BALTIMORE | | 2-15-1968 | | M | | | |
| 10 CITY OR TOWN OF DEATH | | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | | 12b KIND OF BUSINESS OR INDUSTRY | |
| Edgemere | | | | 2805 Wells Avenue | | | | Clerk - Post Office | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE | | | | 13b COUNTY | | | | 13c CITY OR TOWN | | | | 13d INSIDE CITY LIMITS? | |
| Md. | | | | Baltimore | | | | Edgemere | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16b SOCIAL SECURITY NO | |
| Robert | | | | White | | | | Margaret | | | | Langford | |
| 17a | | | | 17b | | | | 17c | | | | 17d | |
| Mrs. Thelma White, 2805 Wells Rd. Edgemere. | | | | ADDRESS Md. 21219 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (b) <u>4127</u> | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | | | | | | | | | | |
| 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | | |
| 20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> | | | | 21b TIME OF INJURY Month, Day, Year | | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| CAUSE OF DEATH | | | | HOUR A.M. P.M. | | | | 19 | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | Charles S. Springate, M.D. | | | | 22b DATE SIGNED | | | | | |
| EXAMINER'S NAME (Type) | | | | Charles S. Springate, M.D. | | | | February 16, 1968 | | | | | |
| 23a BURIAL CREMATION, REMOVAL (Specify) | | | | 23b DATE | | | | 23c NAME OF CEMETERY OR CREMATORY | | | | | |
| Burial | | | | 2/19/68 | | | | Balto. National Cem. | | | | | |
| 24 FUNERAL DIRECTOR | | | | John J. Duda, 7922 Wise Ave. Dundalk, Md. | | | | 25a REC'D BY REGISTRAR | | | | | |
| | | | | | | | | DATE 2 19 1968 | | | | | |
| | | | | | | | | 25b REGISTRAR'S SIGNATURE | | | | | |
| | | | | | | | | | | | | | |

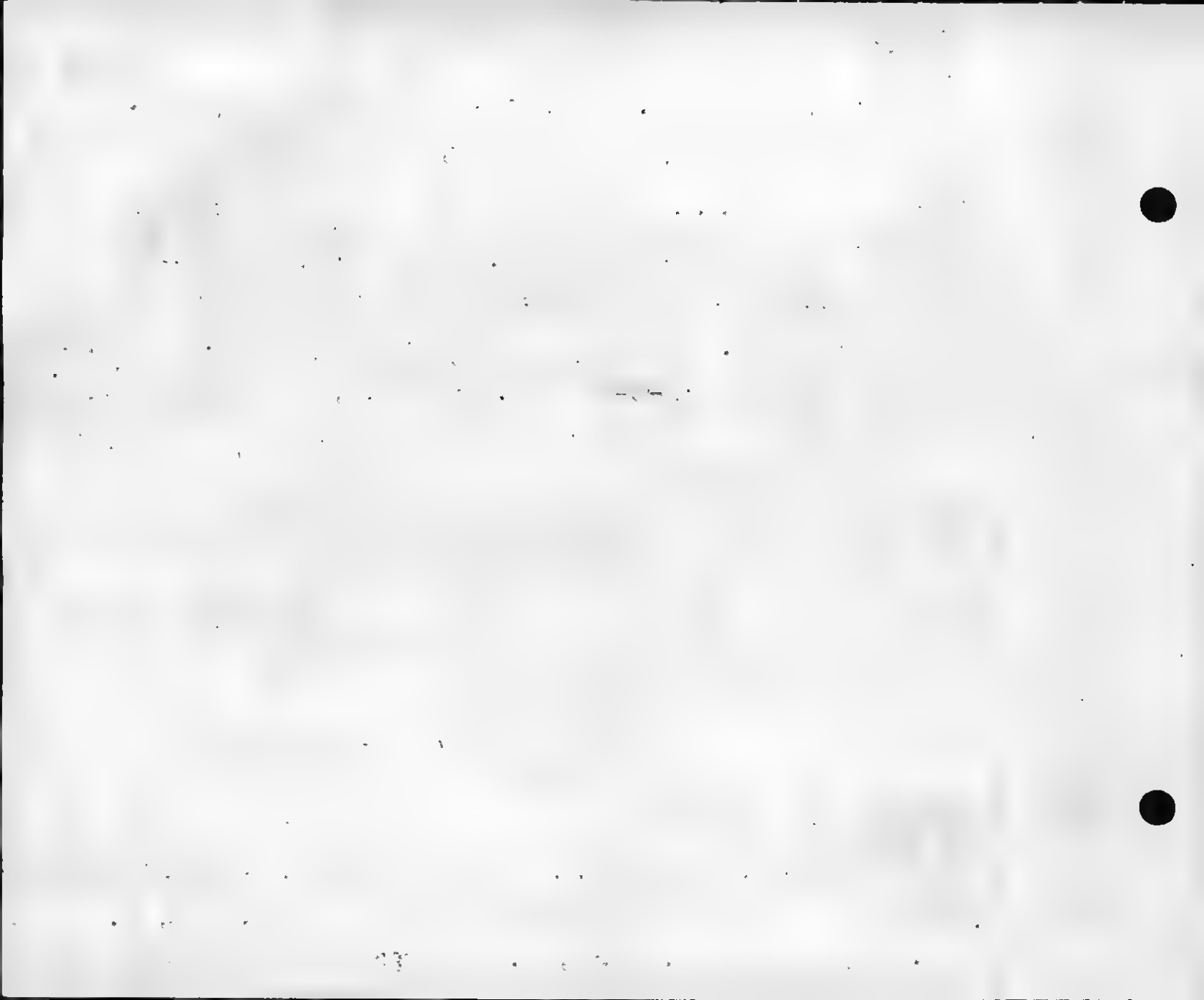


TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|---|---|--|----------------------------------|--|--|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) CHARLES F. WILLIAMS | | | | | | 2a. DATE OF DEATH Feb Month 17 Day 1968 Year | | | 2b. HOUR M | | |
| 3 SEX MALE | | 4 RACE WHITE | | 5. DATE OF BIRTH July 7, 1889 | | | 6. AGE (In years last birthday) 78 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH BALTIMORE Md. | | | | | |
| 10. CITY OR TOWN OF DEATH DUNDALK | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1601 INVERNESS ROAD | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Railroad | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Dundalk | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 1601 Inverness Road | | |
| 14. FATHER'S NAME First Edward Middle M. Last Williams | | | | 15. MOTHER'S MAIDEN NAME First Emma Middle F. Last Martin | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown | | 16b. SOCIAL SECURITY NO. 214-09-8984 | | 17. INFORMANT (Daughter) Mrs. Mary Thacker, 1601 Inverness Road, | | | | Address Dundalk, Md. | | | |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the lungs
16x1 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____ DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 YR. | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 15, 19 68 to Feb 17, 19 68 , that (I) (we) lost the deceased alive on Feb 14 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Stephen C. Mackowiak DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED 2-17-68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) STEPHEN C. MACKOWIAK M.D. | | | | | | 22e. ADDRESS 6714 HOLABIRD AVE. BALT MD. 21222 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 2/20/68 | | 23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Hagerstown, Md. | | | | |
| 24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md. | | | | | | 25a. REC'D BY REGISTRAR DATE Feb 19 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Jones | | | |

MEDICAL CERTIFICATION

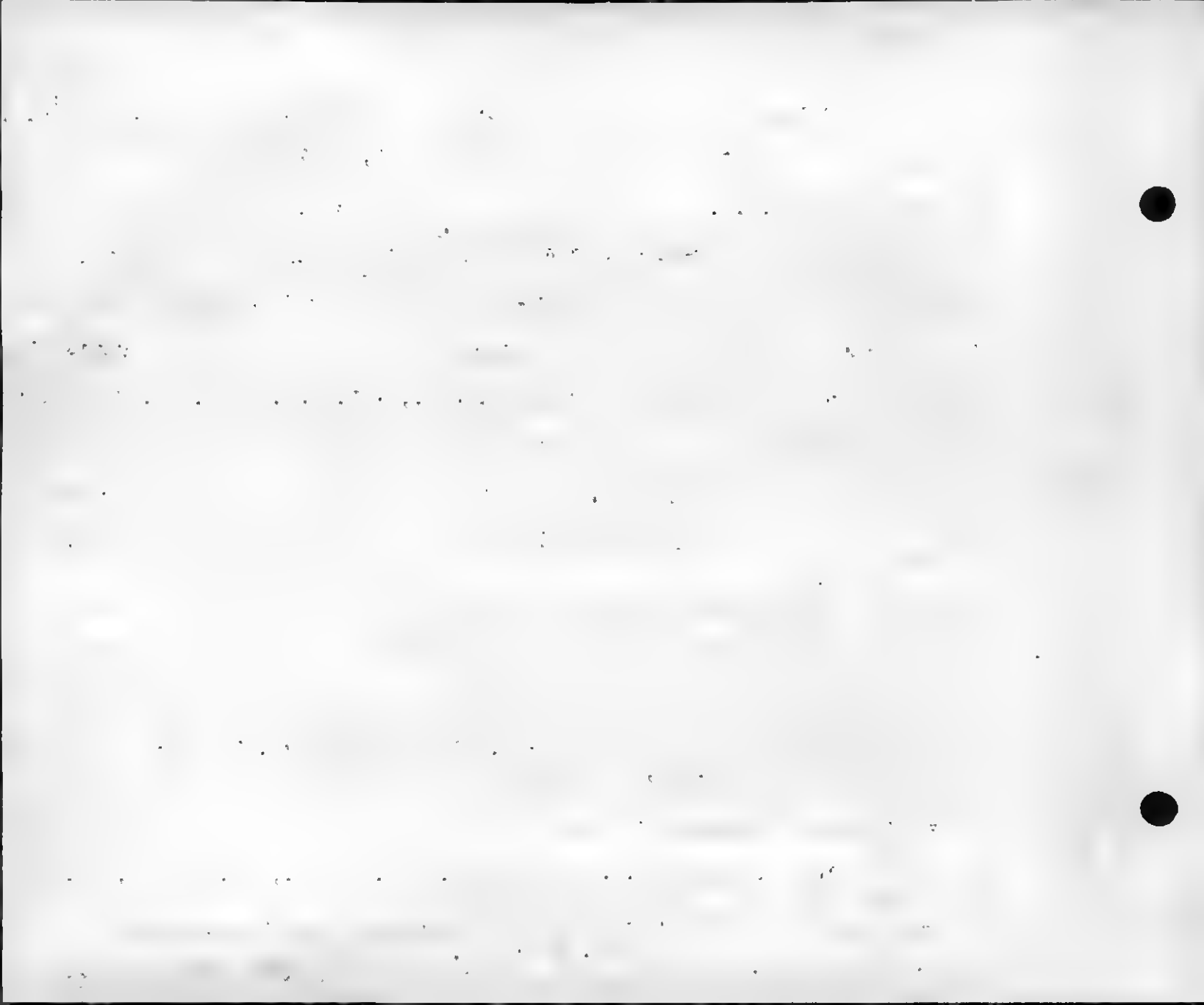


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

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VR A15 (4)
30M REV 1/68

| MAY 9 1968 | | | | | | | | | | MAY 9 1968 | | | | | | | | | |
|---|--|---------------------------------------|--|---|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | |
| 1 DECEASED NAME
(Type or print) | | First | | Middle | | Last | | 2a DATE OF DEATH
Month Day Year | | | | 2b HOUR
a. m. | | | | | | | |
| MC KINNIS | | WILLIAMS | | FEBRUARY | | 24 | | 1968 | | 2:30 | | a. m. | | | | | | | |
| 3. SEX
MALE | | 4. RACE
NEGRO | | 5. DATE OF BIRTH
SEPTEMBER 26, 1927 | | | | 6. AGE (In years last birthday)
40 | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | | | | | | | |
| 7a BIRTHPLACE (State or foreign country)
MASSACHUSETTS | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE | | | | | | Md | | | | | | | |
| 10. CITY OR TOWN OF DEATH
FORT HOWARD | | | | 11. NAME OF HOSPITAL OR INSTITUTION (Hospital name, street address)
VETERANS ADMINISTRATION | | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
SERVICE MAN | | | | 12b KIND OF BUSINESS OR INDUSTRY
RADIO & TV | | | | | | | |
| 13a USUA. RES DENCE (Where deceased lived, if institution Res dence before admission) STATE
MARYLAND | | | | 13b COUNTY
BALTIMORE | | 13c CITY OR TOWN
BALTIMORE | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER
1716 WARWICK AVENUE | | | | | | | | | |
| 14 FATHER'S NAME First Middle Last
ERNEST WILLIAMS | | | | 15 MOTHER'S MAIDEN NAME First Middle Last
Edna Mae Lewis | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) (If yes give war or dates of service)
YES WW-11 | | | | 16b SOCIAL SECURITY NO
421 20 75 16 | | 17 INFORMANT Address
CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD | | | | | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1 DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>ELECTROLYTE EMBOLANCE</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>DIABETES MELLITUS</u> | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 MINUTES
3 DAYS
5 YEARS | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>PANCREATITIS</u> | | | | | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | 21b TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f LOCATION Street or RFD No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that he (this hospital) attended the deceased from <u>Feb. 21</u> , 19 <u>68</u> , to <u>Feb. 24</u> , 19 <u>68</u> , that he (we) last saw the deceased alive on <u>Feb. 24</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b SIGNATURE
<u>Ralph M. Howard MD</u> DEGREE | | | | | | | | ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/24/68 | | | | | | | | | |
| 22d PHYSICIAN'S NAME (Type)
RALPH M. HOWARD, M.D. | | | | | | | | 22e. ADDRESS
VET. ADM. HOSP., FT. HOWARD, MD. | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b DATE
Feb 29, 1968 | | 23c NAME OF CEMETERY OR CREMATORY
Baltimore National Cemetery | | | | 23d LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Nutter Funeral Home | | | | 3035 W. North Ave.
Baltimore, Maryland | | | | 25a. REC'D BY REGISTRAR
DATE FEB 27 1968 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | | | | | | | |



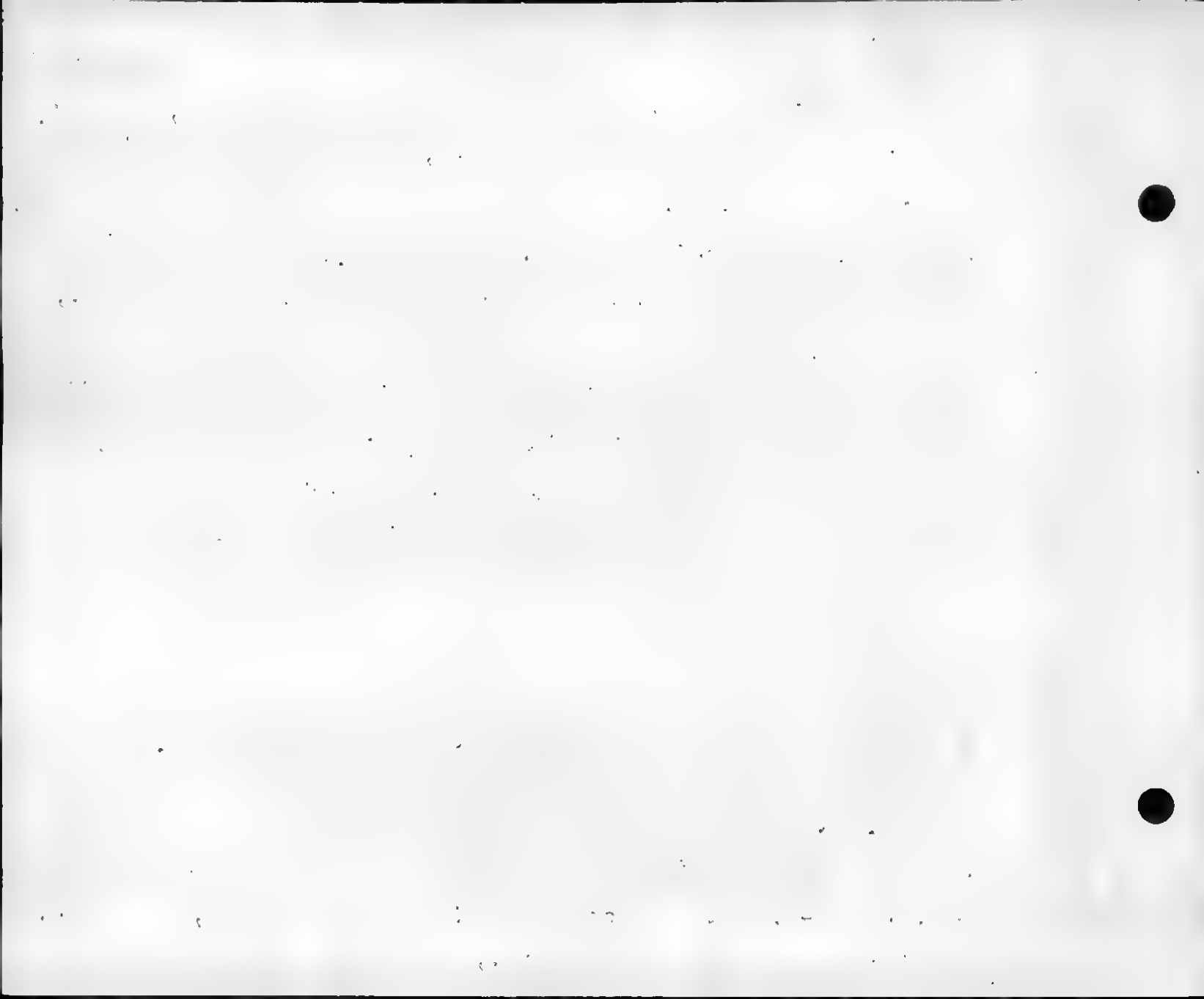
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2

4285

| | | | | | | | | | |
|---|--|---|---|---|--|---|--|--|--|
| 1 DECEASED NAME
(Type or print) | | First Middle Last | | 2a DATE OF DEATH | | Month Day Year | | 2b HOUR | |
| Sophia | | E. Williamson | | Feb. 12, 1968 | | 4 | | M | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6 AGE (In years last birthday) | | 7 NUMBER OF YEARS | |
| Female | | White | | Apr. 29, 1903 | | 81 | | MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | |
| Germany | | U.S.A. | | | | Baltimore | | Md | |
| 10. CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| Catonsville | | St. Luke's Hosp. Home | | Housewife | | At Home | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY 141157
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER | |
| Md. | | Baltimore | | Woodlawn | | | | 5503 W. North Ave., | |
| 14 FATHER'S NAME First Middle Last | | | 15 MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| Christian Kraft | | | Dorothea Zies | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) | | 16b SOCIAL SECURITY NO | | 17 INFORMANT | | Address | | | |
| no | | 216-09-3690 | | Mrs. George V. Wise | | 1201 Cedar Circle Ct | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 4129 IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> | | | | | | | | 3 hr. | |
| DUE TO, OR AS A CONSEQUENCE OF <u>Cardiac failure</u> | | | | | | | | 3 hr. | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | |
| (b) <u>Arteriosclerosis C.V.D.</u> | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/15, 1962</u> , to <u>2/10, 1968</u> , that (I) (we) last saw the deceased alive on <u>1/30, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE | | DEGREE | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c DATE SIGNED | | | |
| 22d PHYSICIAN'S NAME (Type) | | | | 22e ADDRESS | | | | | |
| CLIFF RATLIFF, JR. | | | | 4605 Edmonson Ave. | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | | | |
| Burial | | 2-15-1968 | | Lorraine Park | | Woodlawn, Md. | | | |
| 24 FUNERAL DIRECTOR | | | | ADDRESS | | 25a REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| G. Howard Strong | | | | 3207 W. North Ave., | | FEB 14 1968 | | | |



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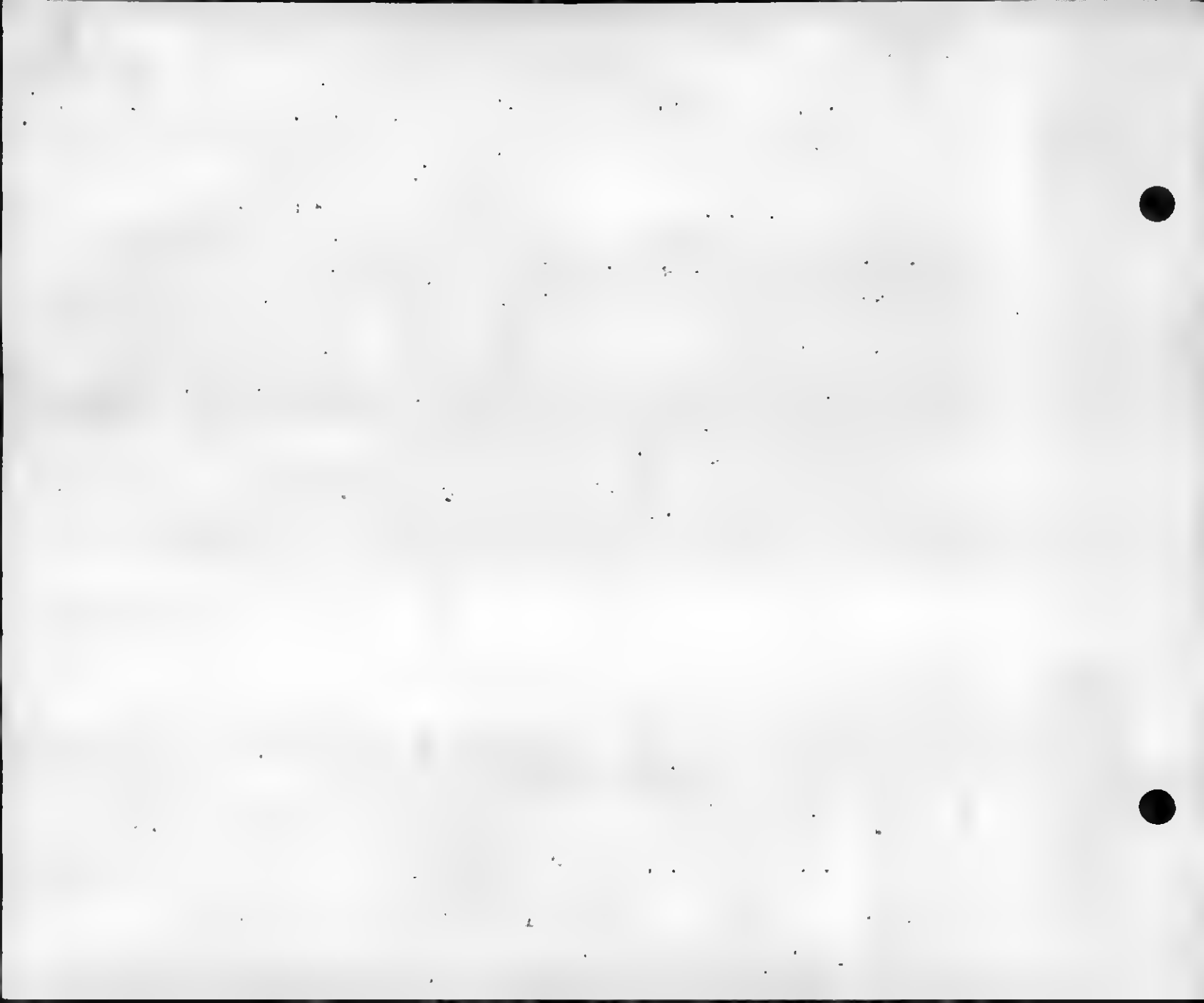
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VR A15 (4)
30M REV 1/68

MD 399
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02386

| | | | | | |
|---|--|--|--|--|--|
| 1 DECEASED NAME
(Type or print) First Middle Last
Joseph Frank Wirth | | 2a DATE OF DEATH
Month Day Year
Feb. 8, 1968 | | 2b HOUR
7:15 P.M. | |
| 3 SEX
Male | | 4 RACE
White | | 5 DATE OF BIRTH
May 21, 1908 | |
| 7a. BIRTHPLACE (State or foreign country)
Hungary | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 6. AGE (In years last birthday)
59 YRS | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH
Baltimore Md | | | |
| 10 CITY OR TOWN OF DEATH
Catonsville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Spring Grove State Hospital | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Printer | |
| 12b. KIND OF BUSINESS OR INDUSTRY
B&O R R | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE
Maryland | | 13b COUNTY
Baltimore | | 13c CITY OR TOWN
Baltimore | |
| 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER
3618 Mary Avenue | | | |
| 14. FATHER'S NAME First Middle Last
John Wirth | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Helen Kanary | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT
Address
Records: Spring Grove State Hospital | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Cardiac failure</u>
401X DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Hypertensive disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | |
| 21d INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from August 12, 1937, to Feb. 8, 1967, that (I) (we) last saw the deceased alive on Feb. 8, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE
A.B. Hooton | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c DATE SIGNED
Feb. 8, 1968 | |
| 22d. PHYSICIAN'S NAME (Type)
A.B. Hooton, M.D. | | 22e ADDRESS
Spring Grove State Hospital | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b DATE
2/10/68 | | 23c NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | |
| 23d LOCATION (City or Town) (County) (State)
Baltimore, Md. | | | | | |
| 24. FUNERAL DIRECTOR
Schimunek Funeral Home, Inc.
3331 Brehms Lane | | 25a REC'D BY REGISTRAR
FEB 13 1968 | | 25b. REGISTRAR'S SIGNATURE | |

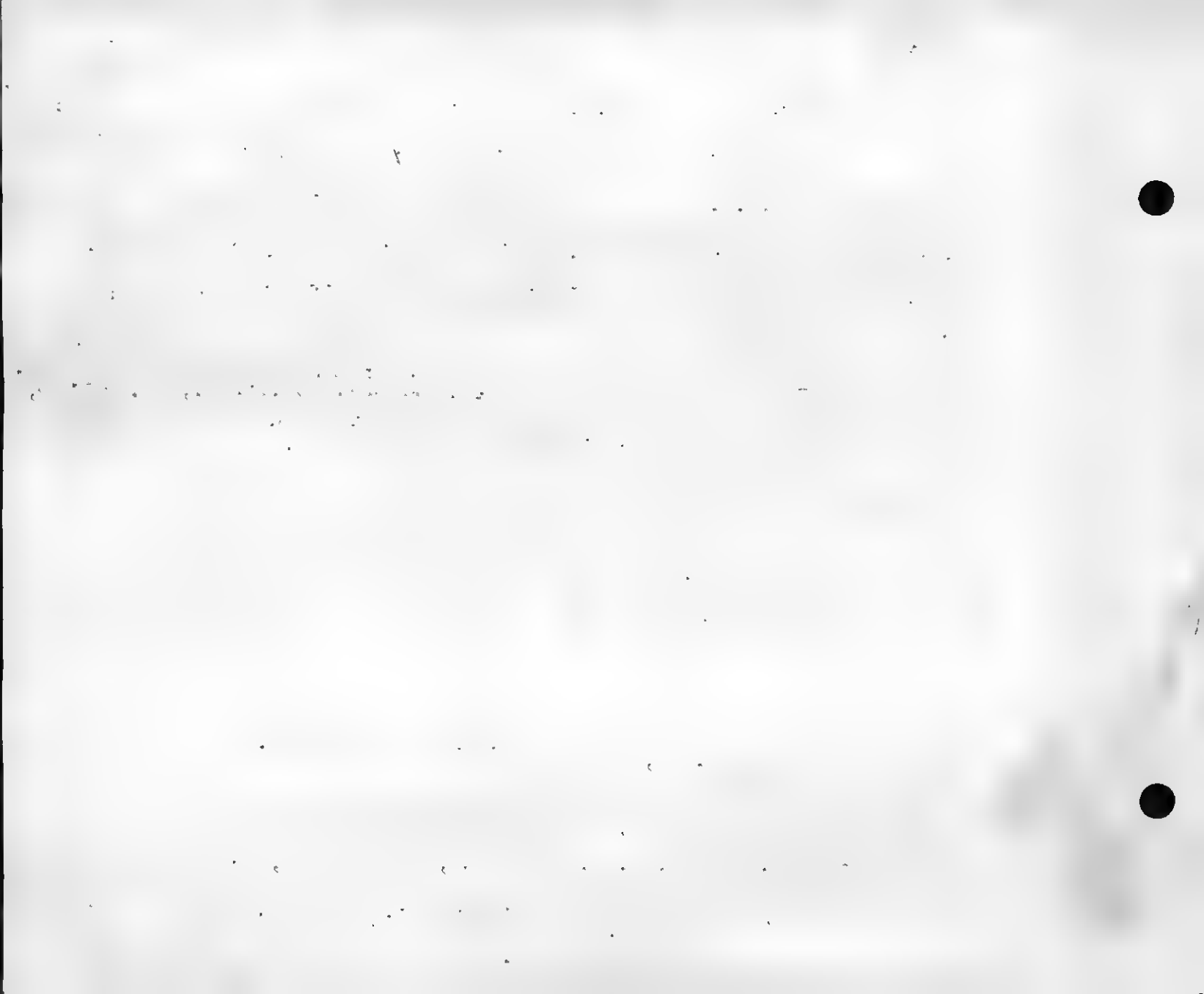


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VR A15 (4)
30M REV. 1/68

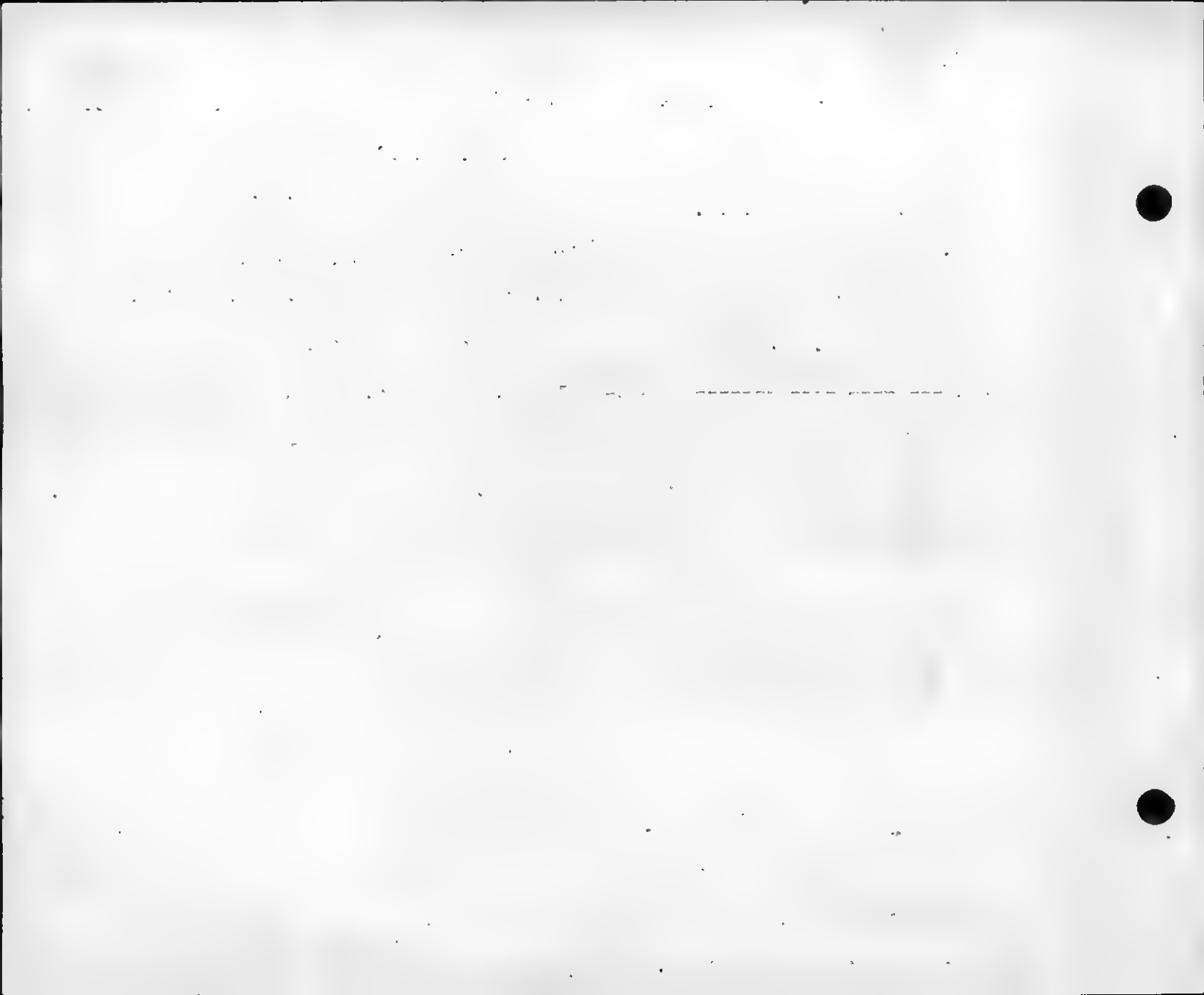
| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|------------------------|--|--|--------------------|--|--|
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR a. | | | | | | | | |
| WILLIAM | | | McKINLEY | | | WOLF | | | 2 24 68 Month Day Year | | | 7:00 M | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | | 7. IF UNDER 1 YEAR | | | 8. IF UNDER 24 HRS | | |
| MALE | | | WHITE | | | 8 13 904 | | | 73 YRS | | | MONTHS DAYS HOURS MIN | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | |
| MARYLAND | | | U.S.A. | | | | | | BALTIMORE | | | | | | Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| FORT HOWARD | | | VETERANS ADM. HOSPITAL | | | AUTO MECHANIC | | | Retired | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER | | | | | |
| MARYLAND | | | | | | BALTIMORE | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 3541 BENZINGER ROAD | | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | | | | | | | |
| ERNEST A WOLF | | | ISABELLE DILSWORTH | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or Unknown) <input checked="" type="checkbox"/> | | | 16b. SOCIAL SECURITY NO | | | 17. INFORMANT | | | Mrs. Anna A. Boffen Address 308 Dover Rd MD. | | | | | | | | |
| YES or Unknown | | | WW-1 | | | 219 01 7563 | | | CLIN. REG. VET. ADM. HOSP. FORT HOWARD | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | Glenburnie, Md. 21061 | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RENAL FAILURE | | | | | | | | | | | | | | 16 DAYS | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 593x | | | | | | | | | | | | (b) | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | |
| GASTROINTESTINAL BLEEDING | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| 2 8 68 | | | AORTIC PLAQUE | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | | | | | | |
| | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION | | | Street or R.F.D. No. City or Town County State | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from Jan. 22, 1968, to Feb. 24, 1968, that (X) (we) last saw the deceased alive on Feb. 24, 1968, and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | | | | | | | | |
| Ralph M. Howard, M.D. DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> 22c. DATE SIGNED 2 24 68 | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) RALPH M. HOWARD, M. D. 22e. ADDRESS VAH, FORT HOWARD, MARYLAND | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | |
| BURIAL | | | 2/28/68 | | | BALTIMORE NATIONAL CEMETERY BALTIMORE | | | BALTIMORE | | | MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | | | | | | | | |
| Hubbard Funeral Home 4107 Wilkens Ave. Baltimore, Md. 21229 25a. REC'D BY REGISTRAR DATE FEB 29 1968 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|---|---|---|--|--|---|-----------------------------------|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1 DECEASED NAME
(Type or print) | | | First
JOHN | | | Middle
TALIAFERRO | | | Last
WORTH | | |
| 2a. DATE OF DEATH | | | Month 2 Day 14 Year 68 | | | 2b. HOUR | | | 1 P. M. | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
Jan. 12, 1914 | | 6. AGE (In years last birthday)
54 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
Ky. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
202 1/2 Bosley Ave. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Trans. Manager | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Baltimore | | | 13c. CITY OR TOWN
Towson | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
202 1/2 Bosley Ave. | |
| 14. FATHER'S NAME First Middle Last
John G. Worth | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Phoebe Beckner | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO
403-05-9897 | | | 17. INFORMANT Address
Mrs. Shirley A. Worth, Same as #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Cerebral vascular thrombosis</u>
4129 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>ASCVD</u>
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>acute</u>
<u>10 XAS</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>4129</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| 21d. INJURY OCCURRED
White <input type="checkbox"/> Not white <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>SEPT</u> , 19 <u>68</u> , to <u>PRESENT</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2/8</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Leon G. Sheer, M.D.</u> DEGREE | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>2/4/68</u> | | | | |
| 22d. PHYSICIAN'S NAME (Type)
LEON G. SHEER, M.D. | | | | | 22e. ADDRESS
6715 PARK HEIGHTS AVE. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Type) | | 23b. DATE
Feb. 15, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Greenmount Crematory | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS
Wm. Cook-Brooks Towson, 1050 York Road
Towson, 21204 | | | | | 25a. RECEIVED BY REGISTRAR
FEB 16 1968 REGISTRAR'S SIGNATURE | | | | | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| <div>Item 31 film 398</div> <div>3-1-1-1</div> <div>402</div> <div>2031</div> | | | | | | | | | |
|--|--------|---|---|--|--|---|--|---|---|
| <div>Item 31 film 398</div> <div>3-1-1-1</div> <div>402</div> <div>2031</div> | | | | | | | | | |
| <div>Item 31 film 398</div> <div>3-1-1-1</div> <div>402</div> <div>2031</div> | | | | | | | | | |
| 1 DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a DATE KNOWN
OF ESTI-
DEATH MATED | | | 2b HOJR |
| HARRISON | | | FILMORE | | | WYATT | | | 25 19 68 1:00 |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | 6 AGE (In years
last birthday) | if UNDER 1 YEAR
MONTHS DAYS | | if UNDER 24 HRS
HOURS MIN. | | 2c DATE PRONOUNCED DEAD
Month Day Year | 2d HOUR |
| Male | White | 2-7-1918 | 50 YRS | | | | | Feb. 25 19 68 1:00 | |
| 7a BIRTHPLACE (State or foreign
country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | |
| Baltimore, Md. | | U.S.A. | | | | Balto. | | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL, OR INSTITUTION (If not in hospital
give street address) | | | 12a USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | 12b KIND OF BUSINESS OR
INDUSTRY |
| Balto. 21204 | | | 619 Piccadilly Rd. | | | B&O, C&O, Director Personell | | | |
| 13a USUAL RESIDENCE (Where deceased
admission) STATE | | | 13b COUNTY | | | 13c CITY OR TOWN | | 3d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e STREET AND NUMBER |
| Md. | | | Balto. | | | Balto. | | 619 Piccadilly Rd. | |
| 14 FATHER'S NAME First Middle Last | | | | | 15 MOTHER'S M A D E N NAME First Middle Last | | | | |
| Harrison Wyatt | | | | | Pearl Hill Denbow | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | 16b SOCIAL SECURITY NO | | 17 INFORMANT ADDRESS | | | | |
| Yes. | | | Navy, U.S. | | Hospital Records | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Subarachnoid hemorrhage
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. (b) DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | 21b TIME OF INJURY Month, Day, Year
HOUR AM | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | |
| | | | 100 xx 2 25 19 68 | | Subject fell down stairs | | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK AT WORK | | 21e PLACE OF INJURY (At home, farm, street,
factory office building, etc.) | | 21f LOCATON Street or RFD No | | City or Town | | County | State |
| | | Home | | | | Baltimore | | Balto | Md |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspect on <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion
death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL
SIGNATURE | | | M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b DATE SIGNED | |
| EXAMINER'S
NAME (Type) | | | Edward F. Wilson, M.D. | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | Feb. 25, 1968 | |
| 23a BURIAL, CREMATION
REMOVAL (Specify) | | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | | |
| Burial | | | 2-27-1968 | | Lorraine | | Woodlawn Balto, Md. | | |
| 24 FUNERAL DIRECTOR ADDRESS | | | | | 25a REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | |
| Wm. Cook-Brooks Towson, Towson, Md. | | | | | FEB 29 1968 | | Charles Judge | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by me (under seal), page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30A REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|---|--|--|--|--|---|-----------------------|---|--|-----------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
LENA | | | Middle
NMI | | | Last
YAFFE | | | 2a. DATE OF DEATH
Month
2 - Day
13 - Year
1968 | | | 2b. HOUR
4:30 P.M. | | | | |
| 3. SEX
FEMALE | | | 4. RACE
WHITE | | | 5. DATE OF BIRTH
5-15-92 | | | 6. AGE (In years
last birthday)
75 YRS. | | | IF UNDER 1 YEAR
MONTHS
DAYS | | IF UNDER 24 HRS
HOURS
MIN | | | | | |
| 7a. BIRTHPLACE (State or foreign
country)
RUSSIA | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
BALTIMORE | | | Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
RANDALLS TOWN | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
BALTIMORE CO. GEN. HOSP. | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired)
RETIRED | | | 12b. KIND OF BUSINESS OR
INDUSTRY
CLOTHING | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Md. | | | 13b. COUNTY
BALTIMORE | | | 13c. CITY OR TOWN
BALTIMORE | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
6500 EBERLE DR. | | | | | | | |
| 14. FATHER'S NAME
First
BENJAMIN | | | Middle
YAFFE | | | Last
RACHEL | | | 15. MOTHER'S MAIDEN NAME
First
JACOBSON | | | Middle
Last | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
NO | | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
213-09-7094 | | | 17. INFORMANT
MRS. SHIRLEY YAFFE | | | Address
6500 EBERLE DR., APT. 203 | | | #21215 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION
4109
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last.
(b) ARTERIOSCLEROTIC CARDIOVASCULAR
DUE TO, OR AS A CONSEQUENCE OF
DISEASE
(c) | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from FEB 8, 1968, to FEB 13, 1968, that (I) (we) last
saw the deceased alive on FEB 13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Fausto Q. Aquino | | | | | | | | | | | | DEGREE
ATTENDING
PHYS. | | <input type="checkbox"/> MED.
DIRECTOR | | <input type="checkbox"/> STAFF
PHYS. | | 22c. DATE SIGNED
2-13-68 | |
| 22d. PHYSICIAN'S
NAME (Type)
FAUSTO Q. AQUINO JR. | | | | | | | | | | | | 22e. ADDRESS
BALTIMORE COUNTY GEN. HOSP. | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
BURIAL | | | 23b. DATE
1-14-68 | | | 23c. NAME OF CEMETERY OR CREMATORY
HEBREW MT. CARMEL | | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | | | | | 25a. REC'D BY REGISTRAR
DATE FEB 14 1968 | | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | |

MEDICAL CERTIFICATION

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1. The first part of the report is a general statement of the work done during the year. It includes a summary of the results of the various projects and a statement of the progress made in each of them. The second part of the report is a detailed account of the work done in each of the various projects. It includes a description of the work done, the results obtained, and the conclusions reached. The third part of the report is a statement of the financial results of the year. It includes a statement of the income and expenses of the various projects and a statement of the net result of the year. The fourth part of the report is a statement of the personnel who have worked on the various projects during the year. It includes a list of the names of the personnel and a statement of the work done by each of them. The fifth part of the report is a statement of the equipment and materials used during the year. It includes a list of the names of the equipment and materials and a statement of the quantity of each of them used. The sixth part of the report is a statement of the conclusions reached during the year. It includes a summary of the results of the various projects and a statement of the progress made in each of them. The seventh part of the report is a statement of the recommendations made during the year. It includes a list of the recommendations and a statement of the reasons for making each of them. The eighth part of the report is a statement of the acknowledgments made during the year. It includes a list of the names of the persons and organizations to whom acknowledgments are made and a statement of the reasons for making each of them. The ninth part of the report is a statement of the references cited during the year. It includes a list of the names of the books, articles, and other references and a statement of the reasons for citing each of them. The tenth part of the report is a statement of the index of the report. It includes a list of the names of the various parts of the report and a statement of the page numbers of each of them.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|---|--|--|--|--|--|--|--|-----------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) MINNIE ZASLOUSKY | | | | | | 2a. DATE OF DEATH FEB Month 18 Day 1968 Year | | | 2b. HOUR 11:35 PM | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH DECEMBER 27, 1883 | | | 6. AGE (In years lost birthday) 84 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) RUSSIA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH XXXXXXXXXX BALTIMORE Md. | | | | | |
| 10. CITY OR TOWN OF DEATH RANDALLSTOWN | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4025 STARBROOK ROAD | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE | | | 12b. KIND OF BUSINESS OR INDUSTRY AT HOME | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | | 13b. COUNTY BALTIMORE | | | 13c. CITY OR TOWN RANDALLSTOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 4025 STARBROOK ROAD | |
| 14. FATHER'S NAME First DAVID Middle KARCHEM Last SARAH | | | | 15. MOTHER'S MAIDEN NAME First SARAH Middle ? Last ? | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. 213-05-6323D | | 17. INFORMANT Address MRS. IRENE F. HESS, 4025 STARBROOK RD. #21133 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Subacute bronchopneumonia
DUE TO, OR AS A CONSEQUENCE OF
(b) Advanced Paget's disease with asystole
DUE TO, OR AS A CONSEQUENCE OF
(c) 4 month | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/5, 1968 , to 2/19, 1968 , that (I) (we) last saw the deceased alive on 2/19, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Stanley M. Rosen M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED 2/19/68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) STANLEY M. ROSEN, M.D. | | | | | | 22e. ADDRESS 4000 W. Northern Pkwy (15) | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 2-20-68 | | 23c. NAME OF CEMETERY OR CREMATORY TZEMECH ZEDEK | | 23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | | | 25a. REC'D BY REGISTRAR DATE FEB 20 1968 | | 25b. REGISTRAR'S SIGNATURE Charles J. [Signature] | | | | | |

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